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ABSTRACT

This document contains a final report of a project which developed a model multidisciplinary graduate curriculum in mental health and aging. The introductory chapter, "Career Preparation: A Curriculum in Mental Health and Aging for Service Providers" (Thomas A. Rich, et al.), includes background information and discussions of the curriculum development process, student characteristics, the project information dissemination process, teaching faculty, the evaluation process, and outcomes. The remaining 10 chapters describe each individual course developed for the mental health and aging graduate curriculum: (1) "Mental Health and Aging" (Thomas A. Rich et al.); (2) "Physical Change, Behavior and Aging" (Sue V. Saxon); (3) "Psychopathology and Aging I" (Larry W. Dupree and Victoria K. Dunn); (4) "Psychopathology and Aging II" (Victoria K. Dunn and Larry W. Dupree); (5) "Mental Health Assessment of Older Adults" (Thomas A. Rich and Susan Turner); (6) "Gerontological Mental Health Counseling I" (Calvin Pinkard and James R. Moon); (7) "Gerontological Mental Health Counseling II" (Jeffrey A. Giordano and Nan Giordano); (8) "Loss and Grief Counseling" (Mary Jean Etten); (9) "Mental Health Systems" (Maureen Kelly et al.); and (10) "Field Placement in Mental Health" (Victoria K. Dunn and Thomas A. Rich). Each course chapter gives information such as course objectives, descriptions, design, requirements, and suggested texts. In addition, information is provided for each session of the course. Session descriptions contain information such as content, key concepts, learning activities and laboratories, suggested readings, and audiovisual resources. The final chapter on field placement describes settings, students, and supervision. A reference list is included at the end of each chapter. (NB)

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CAREER PREPARATION: A CURRICULUM IN MENTAL HEALTH AND AGING FOR SERVICE PROVIDERS

FINAL REPORT
AUGUST 31, 1986
ADMINISTRATION ON AGING
AWARD NUMBER 90AT0146

CG 019701

PROJECT STAFF:

Thomas A. Rich, Ph.D., S.M.Hyg.
Department of Gerontology
Center for Applied Gerontology
J. Neil Henderson, Ph.D.
Suncoast Gerontology Center
Calvin Pinkard, Ph.D.
Department of Rehabilitation Counseling
Larry W. Dupree, Ph.D.
Florida Mental Health Institute
Victoria K. Dunn, M.A.
Center for Applied Gerontology
Diane W. Burr, M.A.
Center for Applied Gerontology
Jeffrey A. Giordano, Ph.D., ACSW
Departments of Gerontology/Social Work

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Thomas A. Rich

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THE DEPARTMENT OF
GERONTOLOGY AND CENTER
FOR APPLIED GERONTOLOGY
UNIVERSITY OF SOUTH FLORIDA
TAMPA, FLORIDA 33620

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PREFACE

This is the final report to the Administration on Aging on the Mental Health and Aging Curriculum Project (Award No. 90AT0146) which was carried out by a multidisciplinary group of faculty members at the University of South Florida from January 1985 to August 1986. It begins with a listing of project staff and others associated with the project in various capacities. Following this, there is an introductory chapter which includes background information as well as a discussion of the curriculum development process, student characteristics, the project information dissemination process, teaching faculty, the evaluation process and outcomes. Lastly, there are chapters dealing with each individual course developed for the mental health and aging graduate curriculum.

We wish to express our appreciation to Shari Allen, Center for Applied Gerontology, Mae Johnson, Department of Gerontology, Peggy Ott, Human Resources Institute, and Deborah K. McPherson, Suncoast Gerontology Center. Our special thanks also go to Wiley Mangum for his editorial assistance.

PROJECT STAFF

Thomas A. Rich, Ph.D., S.M.Hyg., Project Director
Chair, Department of Gerontology
Director, Center for Applied Gerontology
SOC 107, University of South Florida
Tampa, Florida 33620

Calvin M. Pinkard, Ph.D.
Project Co-Director
Chair, Department of Rehabilitation
Counseling, SOC 107
University of South Florida
Tampa, Florida 33620

J. Neil Henderson, Ph.D.
Project Co-Director
Suncoast Gerontology Center
MDC 50
University of South Florida
Tampa, Florida 33612

Larry W. Dupree, Ph.D.
Project Co-Director
Chair, Department of Aging and
Mental Health
Florida Mental Health Institute
University of South Florida
Tampa, Florida 33612

Victoria K. Dunn, M.A.
Project Coordinator
Center for Applied Gerontology
Adjunct Lecturer, Department of
Gerontology, SOC 107
University of South Florida
Tampa, Florida 33620

Diane W. Burr, M.A.
Administrative Specialist
Center for Applied Gerontology
Adjunct Lecturer, Department of
Gerontology, SOC 107
University of South Florida
Tampa, Florida 33620

Jeffrey A. Giordano, Ph.D.
Staff
FMHI/Department of Gerontology
SOC 107
University of South Florida
Tampa, Florida 33620

ADVISORY COMMITTEE

William Emener, Ph.D.
Associate Dean
College of Social and Behavioral Sciences
University of South Florida

Harold Sheppard, Ph.D.
Director
International Exchange Center on Gerontology
University of South Florida

Eric Pfeiffer, M.D.
Director
Suncoast Gerontology Center
University of South Florida

CURRICULUM DEVELOPMENT COMMITTEE

Darlene Calleja, M.A.
Training Specialist
Department of Aging and Mental Health
Florida Mental Health Institute

Gene Dagon, M.D.
Psychiatrist
James A. Haley Veterans Hospital

Mary Jean Etten, Ed.D., C.D.E.
Professor of Nursing
School of Nursing
St. Petersburg Junior College

Wanda A. Dickman, M.S.N.
Head Nurse, Geropsychiatry
James A. Haley Veterans Hospital

Dorothy R. Gagnier, Ph.D.
Associate Coordinator
Education and Training
Suncoast Gerontology Center

Tina Henson, Ph.D.
Associate Professor
Department of Social Work

Maureen Kelly, M.A.
Executive Director
West Central Florida Area Agency on Aging

Bill Kinder, Ph.D.
Associate Professor, Acting Director
Clinical/Community Program
Department of Psychology

Katie Marple, M.S.W.
Relationship Counselor, Aging Program
Family Service Centers of Pinellas County
Lillian Middleton, M.S.W.
Clinical Specialist
Suncoast Gerontology Center

Mary Morgan, Ph.D.
Staff Psychologist/Nursing Home Care Unit
Bay Pines Veterans Medical Center

James W. Noble, M.A.
Alcohol, Drug Abuse, and Mental Health Program Office
Tallahassee

Deborah Pierce-Gaunt, RN, M.S.N.
Director, Adult and Aging Services
Systems Administrator
Geriatric Residential Treatment System
Manatee Mental Health Center

Randa Robinson, M.A.
Assistant Project Director
Community Care for the Elderly
Neighborly Senior Services, Inc.

Vivian Ross, Ed.D., RNC
Professor & Chairperson
Gerontological Nursing Graduate Program

Sue V. Saxon, Ph.D.
Professor
Department of Gerontology

Philip B. Stafford, Ph.D.
Coordinator, C/E Services
South Central Community Mental Health Center
Bloomington, Indiana

Pat Stuart, M.A.
Manager, Aging Services Program
Hillsborough Community Mental Health Center

Deborah Sumner, M.A., RN
Clinical Services Coordinator
Gulf Coast Jewish Family Services

Chapter 1

CAREER PREPARATION: A CURRICULUM IN MENTAL HEALTH AND AGING FOR SERVICE PROVIDERS

Thomas A. Rich, Ph.D., S.M.Hyg.
Chair, Department of Gerontology
Director, Center for Applied Gerontology

Diane W. Burr, M.A.
Center for Applied Gerontology
and
Florida Mental Health Institute

Victoria K. Dunn, M.A.
Center for Applied Gerontology
and
Department of Psychology

and

J. Neil Henderson, Ph.D.
Suncoast Gerontology Center
University of South Florida

FINAL REPORT TO THE ADMINISTRATION ON AGING
Award No. 90AT0146
August 31, 1986

Facilitated by an award from the Administration on Aging, faculty of the Department of Gerontology, the Department of Rehabilitation Counseling, the Suncoast Gerontology Center for Health and Long-Term Care, and the Florida Mental Health Institute of the University of South Florida have developed a model multidisciplinary graduate curriculum in mental health and aging. This unique curriculum is intended to prepare graduate students and graduate-level service providers from diverse and generally non-traditional mental health disciplinary backgrounds to optimize and maximize their professional impact on older persons needing mental health care.

The content of the curriculum was developed by a multidisciplinary faculty/community practitioner group assembled expressly for this purpose by the Project, a factor that constitutes a central feature and strength of the overall endeavor. An intensive, product-oriented, 1-day workshop comprised of selected participants generated the basic design for the curriculum. Specific courses were then developed by faculty/practitioner teams, with reviews by the University Academic Review Committees. The result has been a comprehensive and integrated graduate course sequence of 24 semester hours, including practicum experience. Further, an intensive internship is being designed with selected field sites, including the University's Florida Mental Health Institute.

The mental health and aging curriculum is now an elective specialization track in the graduate offerings of the Department of Gerontology of the USF College of Social and Behavioral Sciences and is available to a wide range of graduate students from many disciplines, thereby enhancing its effectiveness and usefulness. Disciplines participating in the planning and utilization of these courses include gerontology, rehabilitation counseling, psychology, anthropology, sociology, public health, social work, criminal justice, public administration, and nursing. The new curriculum is also offered as a Certificate Program for students and practitioners via USF Weekend College (for employed professionals), summer institutes, and regular departmental credit courses. Collaboration with the Florida Board of Professional Examiners ensures acceptance by the State regarding licensure at the appropriate level in such specialties as mental health counseling and family therapy.

The outcomes of the project within the University include the creation of a new and much needed multidisciplinary graduate specialty training program in mental health and aging and interdisciplinary faculty and practitioner collaboration in the development and teaching of the curriculum -- with the strong possibility for ongoing and fruitful collaboration in other areas of gerontological interest. Outside the University, the project is expected to produce professionals in a variety of disciplines who can more competently develop, organize, and deliver mental health services to the elderly population.

BACKGROUND

Statement of Need

Specific training in mental health and aging has been lacking in the curricula and training experiences of most social and behavioral science disciplines although these disciplines are a necessary part of comprehensive mental health care of the elderly. The rapidly increasing elderly population will require an increase in services that are presently lacking in quantity and expertise. In order to provide the education required, it is necessary to train faculty, students, and practitioners in the current state-of-the-art care of the elderly with mental health problems. In general, there is a need for the development of a knowledge base for mental health workers in gerontology, a need for research on what is needed by practitioners, and research into what works with the elderly client (Schaie, 1978).

A need for multidisciplinary training also exists. A study undertaken by the Association for Gerontology in Higher Education and the Gerontological Society of America and reported in the June, 1980 issue of The Gerontologist reveals the need for study of mental health by students and practitioners in the various areas of the aging network. One hundred percent of the respondents in the fields of clinical psychology, nursing, and social work agreed on the need for study in the area of mental health (Johnson et al., 1980).

Short term training projects have been initiated to address this need. A relevant recent example is a project undertaken by the Institute on Aging, Temple University, in which administrators and educator/supervisors from community agencies were trained in 7 or 14-day programs (Griffin & Gottesman, 1983). The present project deals with mental health and aging content in a more intensive manner as part of the regular curriculum available to a large number of disciplines.

This project was a response to the distinct need for curricular development in Florida and the southeastern region. A survey of the aging network in the State of Florida revealed that aging network personnel, in both administration and direct service, rank education in mental health third as a training area of vital need (Fleming, Green, & Rich, 1982). This curriculum will serve to foster the development of educational programs in a wide range of institutions to improve the health and well-being of the elderly.

Florida has the highest percentage of persons aged 65 and over of any state in the nation (18%). Within Florida, the four counties comprising the Tampa Bay area have the highest percentage of elderly (24%) anywhere in the nation. Based on conservative population projections of the percentage of elderly in our national population, we view the Tampa Bay area from a demographic standpoint as a bellwether natural laboratory in which we may address problems to be faced nationally in the future.

The magnitude of this problem is reflected in these facts: a) mental health problems affect a full 15% of all elderly Americans to a serious degree (Pfeiffer, 1975), b) the elderly population is rapidly growing, c) more disease and hospital episodes occur with increased age, and d) 50-60% of hospital admissions to general medical and surgical wards are elderly people (Adams, 1977). The elderly represent the fastest growing part of the population, who at age 65, still look forward to a long life expectancy (Committee on Aging, 1983). Therefore, the importance of maintaining the self-esteem and general mental health of elderly people is of paramount concern for the health care practitioner.

CURRICULUM DEVELOPMENT PROCESS

A mental health curriculum development meeting was held as a first step in the development of this new program. This took the form of a one-day workshop involving the practitioners and academic professionals listed earlier in this report. The participants were carefully selected to represent a wide range of disciplines and practice levels. In the workshop, they were given a description of the goals and objectives of the Project and related information on mental health licensing criteria. The conferees were encouraged to provide as much input as possible on the content for courses.

From this process, a nine-course (plus internship) mental health curriculum was drafted and then circulated back to the participants for further input and consideration.

Discussion of internship and practicum development was initiated during the early stages of the Project. The Florida Mental Health Institute, a major research and training facility on campus, was involved in this process. In addition, members of the project staff met with Linda Biedermann, Executive Director, Department of Professional Regulations of the State of Florida, to initiate discussion concerning state requirements for licensure in mental health counseling.

Course development teams were selected to proceed with the recommendations of the task forces and to develop the nine courses and internship to meet University and Project specifications. The fourteen-step course approval process is outlined below:

COURSE APPROVAL CHRONOLOGY

1. Individual meetings of project staff members Thomas A. Rich, Victoria Dunn and Diane Burr with the leaders of each of the course development teams.
2. Revision of course outlines to meet University guidelines.
3. Review of Course Approval Forms by representatives of the Dean's Office of the College of Social and Behavioral Sciences - Assignment of course numbers according to guidelines of the Florida Department of Education.
4. Submission of the Course Approval Packet to the faculty of the Department of Gerontology by Thomas A. Rich. Discussion of impact of

the curriculum on the Department. Endorsement of the proposed curriculum received from the Department of Gerontology.

5. Submission of the proposed curriculum to the faculty of the Department of Rehabilitation Counseling by Calvin Pinkard, Project Co-Director. Endorsement received.

6. Individual meetings held between staff members of the Project and chairs of the following departments for review of the proposed curriculum:

    Department of Social Work
    Department of Psychology
    Department of Gerontological Nursing, College of Nursing

   Endorsement of the proposed curriculum was received from each of these departments.

7. Larry W. Dupree, Chair, Department of Aging and Mental Health, Florida Mental Health Institute endorsed the curriculum for that Department and met with the Dean of the College of Public Health for review of the curriculum. Endorsement of the curriculum was received from the College of Public Health.

8. Upon receipt of endorsement by these appropriate units and departments of the University, the Course Approval Packet was presented to the Chair of the Graduate Committee of the College of Social and Behavioral Sciences.

9. Meeting of Graduate Committee members with Thomas Rich, Victoria Dunn, and Diane Burr for review of the proposed curriculum. Unanimous approval of the curriculum received from the members of Graduate Committee.

10. Review of the proposed curriculum by the College Faculty Council.
11. Review of the proposed curriculum by the Dean, College of Social and Behavioral Sciences.
12. Review and approval of the curriculum by the University Graduate Council.
13. Review and approval of the curriculum by the Dean of the Graduate School.
14. Final approval, Office of the Provost.

During the course of the approval process, endorsement for the program was received from the following individuals, departments and colleges:

1. Faculty, Department of Gerontology
2. Thomas A. Rich, Ph.D., Chair, Department of Gerontology
3. Faculty, Department of Rehabilitation Counseling
4. Calvin Pinkard, Ph.D., Chair, Department of Rehabilitation Counseling
5. Faculty and Chair, Department of Social Work
6. Division of Clinical/Community Psychology
7. Department of Psychology
8. Department of Gerontological Nursing, College of Nursing
9. Larry W. Dupree, Ph.D., Chair, Department of Aging and Mental Health, Florida Mental Health Institute
10. Dean, College of Public Health
11. Chair, Graduate Committee, College of Social and Behavioral Sciences
12. Graduate Committee
13. Dean, College of Social and Behavioral Sciences

14. University Graduate Council
15. Dean, Graduate School
16. Office of the Provost

THE CURRICULUM

The curriculum development process has resulted in the addition of nine courses in mental health counseling and an internship to the Master's Program in Gerontology. These courses are available to all master's level students in the University either as a part of the Gerontology Master's Program or as a part of the certificate program. The courses are designed for the semester system, requiring approximately 45 hours of contact for 3 hours of credit. These courses are described in considerable detail in the following chapters and may be described briefly as follows:

1. **Mental Health and Aging**

   This introductory course emphasizes knowledge and understanding of the basic concepts of mental health and aging and presents a positive approach to the mental well-being of older adults.

2. **Physical Change, Behavior and Aging**

   Common normal and pathological physical changes associated with aging are discussed as they affect behavior. Aspects of physical and mental illness and pharmacology with gerontological relevance are surveyed.

3. **Psychopathology and Aging I**

   The basic principles and concepts of psychopathology are examined. Major theories about behavior and behavior change are explored. Common gerontological mental health issues are studied with particular focus on adjustment to change and loss.

4. **Psychopathology and Aging II**

   This course is a continuation of Psychopathology and Aging I. It familiarizes the student with psychopathology relevant to aging. Major topics in the DSM-III are covered.

5. **Mental Health Assessment of Older Adults**

   This course is designed to provide the mental health counselor with a basic understanding of evaluation principles and the application of assessment approaches to older adults.

6. **Gerontological Mental Health Counseling I**

   Mental health treatment modalities and approaches to counseling with older adults are examined. Personality theories and their relationship to counseling are included. Development of a treatment plan through integration of assessment data is emphasized.

7. **Gerontological Mental Health Counseling II**

   This is an advanced course directed at clinical practice with older adults. Appropriate technique and skills are integrated with models of psychotherapy, counseling, and personality development. Primary focus is on intervention with groups, families, and couples.

8. **Mental Health Systems**

Community resources at the local, state, and national levels are examined. Methods of linking the mental health system to other systems are explored. Issues of advocacy, competency, guardianship, ethics, and prevention are addressed.

9. **Loss and Grief Counseling**

A review of all course content in preparation for the final report revealed a lack of systematic coverage in this critical area. This course has been added to the curriculum but has not been offered.

10. **Field Placement in Mental Health**

The internship is a highly structured supervised counseling experience providing mental health services to older adults.

WHERE OFFERED

The courses supported by the Administration on Aging have been offered at the Tampa campus at the University of South Florida, at the Bayboro campus in St. Petersburg and one course has been offered onsite for the Aging and Adult Program Office of Health and Rehabilitation Services of the State of Florida. Descriptions of student characteristics and numbers of students taking the courses will be described in the section on EVALUATION.

STUDENT STIPENDS

The Administration on Aging grant included funds to be used especially for attracting qualified students to the initial offering of the mental health and aging courses. These funds were used as stipends for graduate tuition support during the Spring and Summer, 1986 semesters. The stipends were made available to prospective students on a competitive basis. The following graduate students were awarded Administration on Aging stipends to attend the special pilot offering of Mental Health and Aging courses:

Student	Academic Background		Present Position
Diane W. Burr (2 stipends)	Gerontology German English Lit.	M.A. M.A. B.A.	Staff, Mental Health & Aging Project; Training Director, Aging & Mental Health
Virginia Culbert (partial stipend)	Gerontology English Lit.	M.A. B.A.	Counselor
Kelly Dineen (2 stipends)	Psychology	B.A.	Graduate Student Geront/Mental Health
Gayle Duncan (partial stipend)	Gerontology General Studies	M.A. B.A.	Counselor
J. Hammeleff	Psychology	B.A.	Graduate Student Social Work
Janice Jerger	Social Work Psychology	B.A. A.A.	Graduate Student
Joan Malone (2 stipends)	Soc.Sci.,Ed. Psychology	M.A. B.A.	Secondary Teacher
Laurie McLain (2 stipends)	Gerontology Psychology	M.A. B.A.	Counselor
Grant Metcalf	Social Work	MSW	Social Work Intern
Stacy Miller	Social Work Gerontology Social Sciences	M.A. Certificate B.A.	Social Worker
Shirley Mullinix (2 stipends)	Gerontology Psychology Nursing	M.A. B.A. RN	Staff Nurse, Dept. of Aging Services
Donna Peet (4 stipends)	Gerontology Fine Arts Med. Sec'y	M.A. B.A. A.A.	Case Manager
Dorothy Young	Social Work	BSW	Psychiatric Technician

PROJECT EVALUATION

A fundamental assumption of educators and the educational process is that as we increase the amount of knowledge available to students, influence their attitudes, and introduce new skills to them, they will be more useful in their work with the target population. However, we must gather data at several stages to evaluate this assumption. The following description of the project evaluation will be divided into two sections: evaluation process and evaluation outcome.

EVALUATION PROCESS

The evaluation process for the curriculum project uses a pre/post design based on the KAPE model: Knowledge, Attitude, Practice, Effectiveness. Figure 1 summarizes the evaluation process.

KAPE
Model

Knowledge	1. Open-ended survey	1. Student grades
Attitude	1. Open-ended survey	1. Multidimensional Health Locus of Control, 2. Recognition Assessment - Empathy, 3. Mental Health Locus of Origin
Practice	1. Open-ended survey 2. In-class experiential training 3. Practicum 4. Internship	
Effectiveness	Subjectively Assessed	Objectively Assessed

Figure 1. KAPE model of program evaluation.

Knowledge

Evaluation of the content of the curriculum has been accomplished in a number of ways. The initial curriculum development and review was done by the multidisciplinary faculty/practitioner professionals who participated in the 1-day conference. Additional groups which have reviewed the content are: 1) representatives of a wide range of USF departments; 2) the College of Social and Behavioral Sciences' Graduate Committee; 3) the USF Graduate Council; 4) the Florida Board of Professional Examiners; and 5) students participating in the pilot offerings. Revision, based upon this diverse input, has been an integral part of the project. Acquisition of knowledge by students has been measured continuously by classroom grading.

Attitude

It is often assumed that acquisition of knowledge automatically results in more realistic attitudes. In this project, attitudes have received separate focus. Evaluation of attitude change has occurred primarily through the pre & post questionnaires which contain both objective and subjective elements.

Practice

Where possible, the practice of concepts and skills was integrated into the course content. The mechanisms included the use of case studies, videotaped demonstrations, role playing and classroom exercises, as well as interactions with older adults in the community. Students received valuable feedback about their effectiveness from experiential learning in the courses. The feedback will continue as students enter internship. As described in more detail in the section on internship, students will be carefully supervised on a regular basis. Feedback will be provided for a variety of practices including assessment and group and individual counseling.

Effectiveness

The true effectiveness of this training program will not be obvious until well after individual students have completed their training. Effectiveness will be studied through follow-up of agencies hiring the graduates and of the graduates after they have had more field experience and can provide feedback on the program. Curriculum changes will be implemented as necessary.

In summary, curriculum evaluation is a continuing process based on incorporation of new materials into the program as new knowledge becomes available through research and of adjustment in the program as feedback from service providers is received. This is a particularly sensitive area in mental health as we attempt to get more services to more older people and speed up the process of giving them their full share of mental health services. Regular follow-up studies of practitioners' attention to findings and incorporation of new approaches into existing courses or the addition of new courses are essential for maintaining the quality of an educational program. The Department of Gerontology, established as an institute in 1967, has had seventeen years of continuous experience in the evolution of a program of study to make the curriculum as current and relevant as possible.

EVALUATION OUTCOME

Student Characteristics

Analysis of the characteristics of the 59 students who participated in the first two semesters of pilot offerings reveals great diversity. The ages range from 23 to 82 with a mean of 42.3. Seventy-five percent are female. The majority are currently enrolled in an M.A. degree program (56%), but 33% already have an M.A. while 9% have a B.A. and are not seeking an additional degree. Most (68%) are part-time students. The majority (58%) work in mental health settings and 59% work with older adults or their families. The mean grade point average for Mental Health and Aging course work by all students was 3.3 (on a 4.0 scale).

Goals for taking the mental health and aging courses vary. Student priorities (from highest to lowest) are:

1) work toward a graduate degree
2) aging education
3) mental health education
4) mental health licensure

Objective Data

Thirty-two students voluntarily completed both the pre-test and post-test. Three scales were used in this part of the evaluation process:

(1) The Multidimensional Health Locus of Control (MHLOC) scale was developed by Wallston and Wallston (1981) at Vanderbilt University as a measure of perceived sources of control over one's health. Results of the test are expressed as three independent subscale scores: Chance Health Locus of Control (CHLOC), Powerful Others Health Locus of Control (PHLOC), and Internal Health Locus of Control (IHLOC).

Students were internal in their perception of control over their health (pre-test mean scores: CHLOC = 14.62, PHLOC = 14.12, and IHLOC = 24.59). There were no significant differences between the pre-test and post-test scores on any of the subscales, as expected since the MHLOC is believed to measure trait characteristics. For reference scores, see Figure 2.

Multidimensional Health Locus of Control

Selected scores by type of subject population*:

Subject Population Type	n	Internal	Chance	Powerful Others
Mental Health & Aging Curriculum Students	32	24.59	14.62	14.12
Chronic Patients	609	25.78	17.64	22.54
College Students	749	26.68	16.72	17.87
Healthy Adults	1287	25.55	16.21	19.16
Person engaged in preventive health behaviors	720	27.38	15.52	18.44

* Wallston, K.A. & B.S. Wallston (1981).

Figure 2. Multidimensional health locus of control: Selected scores by type of subject population.

(2) The Recognition Assessment - Empathy Test (RA-E) was developed to be a measure of a person's ability to recognize appropriate empathic responses. Students' scores improved significantly between the pre-test (mean RA-E = 43.69) and the post-test (mean RA-E = 47.50); F(1,31) = 9.67, p = .004. For reference scores, see Figure 3.

Recognition Assessment - Empathy (RA-E)

Means for selected groups*:

Occupation	Mean Score	n
Mental Health & Aging Curriculum Students	47.5	32
Guidance Counselors	46.8	32
Nursing Students, 3rd year diploma	46.2	45
Nursing Students, 2nd year diploma	44.5	38
Social Service Students, 2nd year	42.0	40
Correctional Counseling Students, 2nd year	38.3	19
Secondary School Teachers	35.9	34
Retail Store Managers	33.8	23

Figure 3. Recognition Assessment - Empathy (RA-E): Means for selected groups.

* Source: Learning Designs, Inc. 1975.
Table 7, RA-E Manual Supplement (1975/76)
P.O. Box 648, Station K
Toronto, Ontario M4P 2H1, CANADA

(3) The Mental Health Locus of Origin (MHLO) is designed to measure a person's readiness to perceive human problems in mental health terms. Students' scores did not change over the piloting (mean pre-test MHLO = 77.34, mean post-test MHLO = 77.17) suggesting that the students who took the curriculum were ready to explore mental health approaches.

In summary, students who took the courses were internal in their perception of the source of control over their health and were quite receptive to mental health approaches to conceptualizing human problems. Obviously, a process of self-selection had occurred. Participation in the courses did not alter these characteristics. However, participation did increase the students' ability to recognize appropriate empathic responses.

SUBJECTIVE EVALUATION

The purpose of the subjective evaluation was to elicit student comment on each course along dimensions of knowledge, attitude, classroom teacher technique, suitability of classroom materials, and methods used to simulate actual mental health counseling/practice technologies. Students were surveyed in each course using a mid-course/end-course sequence. Each student responded to a six item open-ended questionnaire which was completed and submitted anonymously. The questions are as follows:

1. Has this course increased your knowledge of mental health?
2. How would you improve this course in the area of knowledge?
3. Has this course changed your attitudes toward mental health? How?
4. How would you improve this course in the area of attitudes?
5. Has this course increased your practice skills in mental health?
6. How would you improve this course in the area of practice skills?

The subjective data were analyzed using a content analysis approach in which the narrative subjective responses were scanned for subject-derived attribute clusters. Once such clusters were identified, the entire sample was scanned for frequency distribution among the clusters.

Evaluation Highlights by Course:

The use of the term "highlights" refers to the content analysis process in which subjective, narrative data are reduced by subject-derived categories. Only those subject-derived categories which were repetitively entered are discussed here. The only exception to this rule is for comments that are particularly insightful, revealing, or otherwise useful and noteworthy to the project staff.

Question-Specific Inter-Class Comparisons:

Responses to each evaluation question have been reduced to frequencies within subject-derived attribute categories. The mid-point/end-point frequencies of each course have been summed to give an overall perspective of student response to the courses offered during the academic year 1985-86.

Each evaluation question will be displayed in a matrix followed by a narrative synopsis based on specific content analysis data.

Question #1: Has this course increased your knowledge of mental health?

Course	n	Positive	Neutral	Negative
GEY 6612	12	12	0	0
GEY 6613	9	8	1	0
GEY 6614	14	14	0	0
GEY 6615	9	8	0	0
GEY 6616	33	25	4	3
GEY 6617	11	10	1	0
GEY 6618	29	27	0	2
TOTAL	117	104	7	5

Synopsis:

About 90% of the students report a positive change in their knowledge of aging and mental health. Benefits cited repeatedly include an overall gain in knowledge in mental health and aging, the delineation of mental health problems of the elderly, effects of physical conditions on mental status, increased awareness of personality theories, improved understanding of the classification system in mental health practice, improved confidence in use of the DSM III, improved awareness of assessment and treatment strategies of older mental health clients, beneficial synthesis of theoretical basis of mental health treatment with concurrent exposure to instruments and methods, and learning specific counseling techniques useful with mental health problems in older clients.

Question #2: How would you improve this course in the area of knowledge?

Course	n	Content	Presentation Format	Text	No Change	Not Answered
GEY 6612	12	10	4	3	1	1
GEY 6613	9	1	0	0	5	3
GEY 6614	14	6	5	0	3	0
GEY 6615	9	0	0	1	5	3
GEY 6616	33	7	11	2	5	8
GEY 6617	11	6	5	0	4	0
GEY 6618	29	3	5	0	9	13
TOTAL	117	33	30	6	32	2

Synopis:

About 51% of the students specifically indicated that no change was required in the course or did not feel strongly enough about changes to enter a response. However, the other 49% suggested changes in content, presentation format, and text. The main issue addressed by students was a reflection of the practitioner orientation of the entire curriculum. Specifically, most changes were related to the desire for more clinical skills experience whether in-class simulations or out-of-class experiences with older clients. This zeal for clinical experience reflects students' eagerness to be practitioners rather than a fault of the curriculum. However, it should be noted that each course, with the exception of the "Physical Change, Behavior and Aging" course, did include experiential exercises designed to prepare the student or improve actual clinical skills in mental health counseling with older people. Specific comments related to a need for familiarity with psychological terms for students who have a meager psychology background, actual practice with assessment instruments, more discussion of the impact of assessment on the client, and a wistful desire for more time in courses related to counseling skills.

Question #3: Has this course changed your attitudes toward mental health? How?

Course	n	Improved	No Change	Worsened	No Response
GEY 6612	13	9	4	0	0
GEY 6613	8	5	3	0	1
GEY 6614	13	8	5	0	0
GEY 6615	9	4	5	0	0
GEY 6616	33	13	15	0	5
GEY 6617	11	8	3	0	0
GEY 6618	29	10	15	2	2
TOTAL	116	57	50	2	8

Synopsis:

Specific comments indicate that, of subjects who reported no change in attitudes toward mental health, 43% indicated that they felt in possession of a positive attitude toward mental health prior to taking specific courses. About 49% of respondents reported an improved attitude as a result of participation in the curriculum. Specific remarks include: an increase in the awareness of the prevalence of mental health problems in older people, increased perseverance regarding the establishment of individual independence in a client, increased appreciation of assessment tests, increased awareness that age is no barrier to mental health treatment, learning of the broad ranges of problems that can be effectively treated in older clients, increased patience and awareness, more balanced multidisciplinary view, more cautious regarding diagnosis, and more aware of the importance of the longitudinal data.

Question #4: How would you improve this course in the area of attitudes?

Course	n	Content	Text	Presentation Format	No Change	Don't Know	No Response
GEY 6612	13	6	0	0	1	4	2
GEY 6613	-	-	-	-	-	-	-
GEY 6614	13	3	0	1	6	4	0
GEY 6615	9	1	0	1	4	0	3
GEY 6616	33	3	0	5	2	8	15
GEY 6617	11	1	0	0	3	5	2
GEY 6618	29	0	0	1	9	3	16
TOTAL	108	14	0	8	25	24	38

Synopsis:

Only about 20% of subjects effectively responded to Question #4, the remainder indicating no change, don't know, or had no response at all. Of those indicating changes for improving the courses in attitude, comments were primarily in the area of content and presentation format. Specific entries include: the need to foster an empathic quality in students, give an "ageism" attitude survey and discuss results, encourage students to share their feelings, emphasis on the effects of mental health problems on a person's life as a strategy to increase empathy for them.

Question #5: Has this course increased your practice skills in mental health?

Course	n	Increased	Questionable	N/A	No Change	No Response
GEY 6612	13	6	3	1	1	2
GEY 6613	-	-	-	-	-	-
GEY 6614	13	8	0	4	1	0
GEY 6615	9	7	1	1	0	0
GEY 6616	33	17	4	4	10	1
GEY 6617	11	9	2	0	0	0
GEY 6618	29	26	0	1	0	2
TOTAL	108	73	10	11	12	5

Synopsis:

This question obviously applies to courses that are more specifically practice oriented such as the Counseling Skills I & II courses. Also, the Psychopathology and Aging I & II courses contained specific comments related to practice skills. Regarding the latter courses, specific comments include an improved ability to understand the etiology of specific mental health problems, and an improved ability to make proper diagnosis including use of the DSM III. With regard to the counseling courses, there was nearly universal consensus that practice skills had been improved. Specific comments include the newly acquired capability to engage in crisis counseling with elderly people, beneficial result of labs in class on interviewing and crisis counseling skills, and, very importantly, an increased awareness of individual skills deficits.

Question #6: How would you improve this course in the area of practice skills?

Course	n	In-class Interviews	Out of class Interviews	Tape	Don't Know	No Response	No Change	NA	Presentation Format	Case Studies	Guest Speakers	Role Playing
6612	13	5	2	2	3	5	0	0	0	0	0	0
6613	-	-	-	-	-	-	-	-	-	-	-	-
6614	13	1	4	0	2	0	2	4	1	1	0	0
6615	9	0	0	1	2	3	0	0	0	3	0	0
6616	33	13	0	4	5	8	2	0	0	0	0	0
6617	11	6	0	2	4	0	0	0	0	0	1	1
6618	29	0	2	1	11	7	0	0	0	4	0	0
TOTAL	108	25	8	10	27	23	4	4	1	8	1	1

Synopsis:

As with Question #5, this question is most relevant to the Psychopathology and Counseling courses. Desired improvements in the courses regarding practice skills included these specific suggestions: a desire to observe actual therapy sessions, an increase in the use of case studies in class, the use of videotapes showing specific symptomatology of mental health disorders, and more in-class interview practice.

SUBJECTIVE EVALUATION SUMMARY

The subjective evaluation summaries reveal a high level of satisfaction with curriculum content. The primary reason for the curriculum project (that is, to fill a gap in training and practice of mental health professionals with elderly clients) was mirrored by the students' desire for additional content and experiential training regarding mental health counseling with older clients. The relevance of course topics and course content to actual practice in the field was woven into the curriculum before the classes ever began via the community based curriculum development conference held in the early part of this project. The merit of such practitioner input to an academic program is clear.

Specific refinements of this project will include a slight increase in the use of experiential educational techniques plus videotape and film. However, faculty are aware of the need to provide fundamental knowledge and techniques upon which students must build to gain real competence.

OVERALL SUMMARY

In summary, the effectiveness of the project was assessed by subjective and objective methods. Both evaluation methods document significant student gains in knowledge about mental health and aging. The very important attitudinal dimension revealed students were prepared to engage in studies in mental health issues leading to effective clinical skills with older clients. Objective methods showed a sample characterized by high internal control of health, an ability to recognize empathic responses which improved over the months, and an ability to perceive problems in mental health terms. Subjective data indicate that about half of the subjects felt themselves to have a positive attitude regarding mental health prior to the curriculum and about half reported an improvement which could possibly account for the increase in empathic recognition scores.

Practice skills increased, according to student self-assessment and faculty grading in the counseling skills courses. Practice and internships are still to be completed.

The true effectiveness of this training program will not be obvious until well after individual students have completed their training. The program's effectiveness will ultimately be tested by the performance of its students in agencies of employment.

DISSEMINATION

Dissemination of information about the mental health and aging curriculum has been an important aspect of the project because of the need to recruit a sufficient number of qualified students to enroll in the pilot course offerings. This was accomplished through a variety of methods. Initial announcement of the awarding of the grant for the development of the graduate curriculum was made through press releases to local newspapers, as well as in a booklet of mental health events published quarterly by a local community mental health center.

A mailing list of potential students was compiled from several sources: names of current and former graduate students of the Department of Gerontology; names of agencies serving older adults and/or mental health clients; requests for information received through sign-up sheets made available at a variety of appropriate conferences attended by various staff members during the year. Periodic newsletters containing updated information on various aspects of the curriculum (course approval, licensure, certificate program, semester course schedules, and registration) were mailed to potential students and persons who expressed an interest in being kept informed of developments. These curriculum project updates were also distributed at a number of meetings and conferences throughout 1985-86 and were provided to those university departments whose graduate students might consider mental health and aging courses as electives (i.e., Social Work, Rehabilitation Counseling, Public Health, Anthropology, Psychology, and Sociology).

Early efforts at dissemination of information included:

1. Materials and posters prepared for February 13, 1985 conference, "Understanding and Coping with Dementia," sponsored by the Suncoast Gerontology Center, Tampa. (D. Burr & V. Dunn)
2. Information presented at April 14, 1985 meeting of Department of Health and Rehabilitative Services Aging and Adult Services Program Office Advisory Committee, Tallahassee. (L. Dupree)
3. Inclusion of information in presentation, "Aging in the 21st Century," at May 28-31, 1985 annual conference of the Southern Gerontological Society, Tampa. (T. Rich, J. Giordano)
4. June, 1985. Poster and information display, College of Social and Behavioral Sciences, USF. (D. Burr, T. Rich)

A major effort toward disseminating information about the project at the national level was made through proposals for presentations at the annual conference of several gerontology societies. All proposals were accepted and the following presentations were made during 1985-86:

1) September 11, 1985. 1985 Florida Aging Network Training Workshop. "Models for Program Development: Effective Florida Programs," Orlando, FL. (V. Dunn, D. Burr)
2) November 22-26, 1985, New Orleans, LA. Annual Scientific Conference of the Gerontological Society of America. Discussion Session: "Issues in Mental Health and Aging Curriculum Development." (T. Rich, N. Henderson, C. Pinkard, V. Dunn, L. Dupree) Materials were prepared and disseminated by D. Burr.
3) February 28-March 2, 1986, Atlanta, GA. Annual meeting of the Association for Gerontology in Higher Education.

a) Discussion Session: "Curriculum of a Third Kind: Moving into a New Age by Degrees." (T. Rich, V. Dunn, L. Mullins, J. Giordano).

b) Symposium: "Gerontology Counseling Courses: New Ideas, Strategies, and Approaches - Development of a Mental Health and Aging Curriculum." (T. Rich, J. Moon)

c) Exhibit: Mental Health and Aging Curriculum Project. (D. Burr)

4) April 28-May 1, 1986, Norfolk, VA. Annual meeting of the Southern Gerontological Society. Poster Session: "Educating Mental Health Providers for Older Consumers." (D. Burr, V. Dunn, T. Rich)

Materials presented at the Gerontological Society of America meeting in November appeared in the December, 1985 issue of the Journal of Applied Gerontology, a refereed journal, as a brief report entitled "The Development of a Mental Health and Aging Curriculum" (Rich, et al., 1985).

The Mental Health and Aging Curriculum project has been included in Higher Education in Florida: A Resource Inventory, published by the Florida Consortium of University Centers on Aging and edited by Thomas Rich and Max Rothman (1986).

The final major dissemination effort will be the distribution of the final report to selected agencies, universities, and individuals. It is estimated that 500 copies of this report will be distributed.

FACULTY

Listed below are those faculty who conducted the mental health and aging courses in the pilot testing phase of the grant during the Fall, Spring, and Summer semesters of 1985-86.

GEY 6612 - Mental Health and Aging Fall, 1985 - Tampa Campus

Instructors: Thomas A. Rich, Ph.D., Department of Gerontology
J. Neil Henderson, Ph.D., Suncoast Gerontology Center
Jeffrey Giordano, Ph.D., Departments of Social Work and Gerontology

GEY 6612 - Mental Health and Aging — Summer, 1986 - on site, Health and Rehabilitation Services

Instructor: Jeffrey Giordano, Ph.D., Departments of Social Work and Gerontology

Summer, 1986 - St. Petersburg Campus

Instructor: Beverly Burton, M.A., Adjunct Lecturer, Department of Gerontology

GEY 6613 - Physical Change, Behavior and Aging — Fall, 1985 - Tampa Campus

Instructor: Sue V. Saxon, Ph.D., Department of Gerontology

GEY 6613 - Physical Change, Behavior and Aging — Summer, 1986 - Tampa Campus

Instructor: Sue V. Saxon, Ph.D., Department of Gerontology

GEY 6614 - Psychopathology and Aging I — Fall, 1986 - Tampa Campus

Instructors: Larry W. Dupree, Ph.D., Department of Aging and Mental Health
Florida Mental Health Institute
Victoria Dunn, M.A., Department of Psychology

GEY 6614 - Psychopathology and Aging I — Summer, 1986 - Tampa Campus

Instructor: Larry W. Dupree, Ph.D., Department of Aging and Mental Health
Florida Mental Health Institute

GEY 6615 - Psychopathology and Aging II — Spring, 1986 - Tampa Campus

Instructors: Victoria Dunn, M.A., Department of Psychology
Larry W. Dupree, Ph.D., Department of Aging and Mental Health
Florida Mental Health Institute

GEY 6616 - Mental Health Assessment of Older Adults — Spring, 1986 - Tampa Campus

Instructors: Susan Turner, Ph.D., Florida Mental Health Institute
Thomas A. Rich, Ph.D., Department of Gerontology

GEY 6616 - Mental Health Assessment of Older Adults — Summer, - 1986 St. Petersburg Campus

Instructor: Mary Morgan, Ph.D., Psychological Services,
Bay Pines Veterans Administration Hospital

GEY 6617 - Gerontological Mental Health Counseling I — Fall, 1986 - Tampa Campus

Instructors: Calvin Pinkard, Ph.D., Department of Rehabilitation Counseling
James R. Moon, Ph.D., Residential Aging Program, Florida Mental Health Institute

GEY 6618 - Gerontological Mental Health Counseling II Spring, 1986 - Tampa Campus

Instructor: Jeffrey Giordano, Ph.D., Departments of Social Work and Gerontology

GEY 6619 - Mental Health Systems Summer, 1986 - Tampa Campus

Instructors: Maureen Kelly, M.A., Executive Director, West Central Florida Area Agency on Aging
Thomas A. Rich, Ph.D., Department of Gerontology

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Chapter 2

MENTAL HEALTH AND AGING

Thomas A. Rich, Ph.D., S.M.Hyg.
Chair, Department of Gerontology
Director, Center for Applied Gerontology

J. Neil Henderson, Ph.D.
Suncoast Gerontology Center

Jeffrey A. Giordano, Ph.D., ACSW
Departments of Gerontology and Social Work

COURSE DEVELOPMENT CONSULTANT

Michael O' Sullivan, M.A.
Department of Aging and Mental Health
Florida Mental Health Institute

GEY 6612

MENTAL HEALTH AND AGING

Course Objectives

1. To introduce terms and definitions used by practitioners in mental health and aging
2. To present a positive approach to the mental health of the elderly by emphasizing mental well-being and by exploring sources of negative attitudes
3. To introduce students to the mental health delivery system
4. To explore age-specific risks to the mental well-being of older adults and the resources necessary for successful coping

Course Description

Content:

1. Language, terms and definitions commonly used by practitioners in mental health and aging
2. An overview of the impact of age-related physical changes on the mental health of older adults
3. A developmental perspective on mental well-being and developmental tasks
4. Examination of myths and stereotypes of mental health and aging
5. Individual and societal attitudes toward aging, older adults and mental health
6. Epidemiology and demography of mental health and aging
7. Introduce health promotion, prevention and intervention

activities related to mental health in late life

8. The mental health delivery system -- public/private, professional/paraprofessional, formal/informal mental health practice as well as current and future trends in service delivery
9. The impact of social support systems on mental well-being
10. Common diagnoses in mental health
11. Cultural diversity in the use of the mental health delivery system and in the definition of mental well-being
12. Ethical practice, client rights, professional ethics and current legal issues
13. Current social and economic policy related to mental health concerns

This course is characterized by didactic instruction supplemented by experiential learning in class and in the community. Approximately 70% of class time is devoted to lecture and discussion with 30% of the time used for experiential learning, including various participatory learning activities. Team teaching is used to maximize contact with a variety of faculty. Interview techniques are developed in small groups with supervision by the faculty, and audiovisual instruction is used throughout the 16-week semester. Nearly all sessions include readings from a required text.

Students participate in an experimental term project. They are required to conduct practice interviews with older persons from the community. These interviews are taped and reviewed in class.

This course is designed to stand alone as an overview of mental health and aging. Also, it can be used as the first in a series of courses that would equip the student with the skills and knowledge base to be a service provider in mental health.

The required text for this course is Aging and Mental Disorders by S. Zarit (1980). The format of the book is reflected in the organization of this course. Use of another text would modify the outline.

Course Requirements

Course requirements include one essay examination on all assigned reading and participation in class exercises. The course examination is given at the 10th week in preparation for the experiential activities that follow. The essay examination requires the application of course content to practical problems likely to be encountered in the workplace.

SESSIONS

SESSION 1: ISSUES IN MENTAL HEALTH AND AGING

Overview of Session Content

The first class week is organizational and provides an introduction to the content, format and faculty involved in team teaching of the course. The course objectives and topics to be covered are reviewed. The faculty and students provide a description of their own background in mental health, aging and human services. Knowing the range of education and experience in the class helps keep the course on target.

In sum, the first week emphasizes that becoming a mental health practitioner requires an integration and synthesis of new content and self learning through a process of didactic instruction and group interaction.

Key Concepts

1. Historical information on the mental health movement, federal assumption of responsibility for mental health services and landmark legislation in the mental health area are introduced.
2. The role and need for gerontologists trained in mental health to work with the elderly in a variety of settings are discussed.
3. The application of the general principles and concepts of mental health in administration and supervision as well as in the provision of direct services is examined.
4. Information is introduced on the development of counseling methods appropriate for the aged. Brief mention at this point would be made of life review therapy, group treatment methods, and behavioral training.
5. The educational basis for the experiential exercises in the class and in future courses is discussed.
6. A life review exercise provides a vehicle for group sharing and for a practical introduction of the life cycle perspective.
7. Cross-cultural and generational perspectives and their impact on information and attitudes about mental health and mental illness are introduced.

Learning Activities/Labs

Toward the end of the class meeting, students are asked to arrange themselves in a circle and are given pipe cleaners as material for an exercise. They are asked to review their personal life history and the "ups" and "downs" they have experienced. The task is to transfer these life experiences into graphic form by bending the pipe cleaner into peaks and valleys. Group discussion ensues regarding life course development.

Suggested Readings

Zarit, Chp. 1: Mental health and aging: An overview.

SESSION 2: EPIDEMIOLOGY AND MENTAL HEALTH SERVICES

Overview of Session Content

The basic concepts of mental illness and aging are introduced with a systems perspective. The provision of services and the utilization of services by the elderly is discussed from a historical perspective. The general societal attitudinal changes that have taken place about mental illness are reviewed with a particular emphasis on hospitalization and the impact of psychotropic medication beginning in the 60's.

Special attention is given to the social context of aging, emphasizing the heterogeneity of the elderly population and the influence of the sociocultural environment. Cross-cultural examples illustrating the social context of aging are used to enhance the students' ability to introspectively observe their own age biases and the biases of their clients.

Key Concepts

1. The incidence and prevalence of mental illness.
2. Comparisons of cross-sectional, longitudinal, and cross-sequential research designs.
3. In the context of epidemiological and demographic information: introduction to dementia, depression, functional psychosis, anxiety states, and other major mental health disorders.
4. Discussion of the organization of mental health services delivery to the elderly at federal, national, regional, and local levels.

5. The staffing of mental health programs and disciplinary differences in background, training, and perspectives of social work, psychology, psychiatry, mental health counseling, nursing, gerontology, and other fields offering mental health services.
6. The role of direct service agencies in the provision of mental health services to the elderly is discussed. In many agencies, counseling, referral, and recognition of severe problems occurs on a regular basis but are not recognized as a major mental health service function. Mental health service delivery can occur in family counseling, community care for the elderly programs, nutrition programs, peer counseling, and in the whole range of organizations.

Learning Activities/Labs

Lecture and case discussion.

Suggested Readings

Zarit, Chp. 1: Mental health and aging: An overview (Cont'd).

Zarit, Chp. 2: Biological and psychological processes of aging.

SESSION 3: SOCIAL POLICY AND TREATMENT OF OLDER AMERICANS

Overview of Session Content

The Community Mental Health Act and related state policies are discussed and current social policy issues are introduced. Definition of social policy and the relevance of social policy for the practitioner is covered. Current social policy is reviewed in terms of its relationship to social services for the elderly, specifically mental health services. Briefly noted are the Older Americans Act, Social Security, and Medicare. The lack of specific social policy directly related to mental health and aging is analyzed. The students are also introduced to treatment approaches in mental health for the elderly and across the life span. The historical basis for different therapeutic approaches is developed and related to current practice trends.

The predominant approaches to the mentally ill elderly have been chemical and behavioral because in many settings elderly patients are seen as management problems. There is some indication that client centered/humanistic, psychodynamic, and more eclectic approaches are increasingly being applied in many settings.

Key Concepts

1. Mental health aspects of current social policy legislation and programs.
2. Definition of social policy.
3. Need for special social policy related to mental health and aging.
4. Psychodynamic, humanistic/client centered, learning theory/behavioral, chemical therapy.
5. Relationship of human behavior theories to treatment methods.

Suggested Readings

Zarit, Chp. 4: Social problems and social policy.

SESSION 4: PERSONALITY THEORIES AND UNIQUE AGE RELEVANT FACTORS

Overview of Session Content

The discussion of therapeutic approaches to the elderly is continued from the preceding week and related to personality theories. Questions of personality theory and personality change over time are discussed.

Key Concepts

1. The concept of cohort groups is introduced.
2. Extended discussion of longitudinal, cross-sectional, and cross-sequential studies.
3. Discussion of intellectual growth and decline over time and the impacting factors, including the concept of terminal decline.
4. The relationship between illness and age change.

Learning Activities/Labs

Lecture, discussion, and cohort group comparison exercise. Students are asked to compare all the possible differences that might account for why one group (average age 30) and another group (average age 60) might differ in some ways when measured. Students are encouraged to think of possibilities that might explain differences between these groups including such things as rural/urban background, educational level, test-taking practice, health status, child rearing philosophies, political attitudes, attitudes toward women, attitudes toward divorce, wars which are used as reference points, depression vs. boom times, and so on.

Suggested Readings

Zarit, Chp. 3: Personality and aging.

SESSION 5: MAJOR MENTAL HEALTH PROBLEMS OF THE ELDERLY - ASSESSMENT

Overview of Session Content

This session begins a three week series focused on the major mental health problems of the elderly. Students are introduced to current information about the causes, assessment procedures, and treatment for major mental health problems of the elderly. The student also observes and discusses a comprehensive assessment of an elderly person. In this case, a thirty minute videotape demonstrating the functional assessment inventory by a clinical gerontologist is used.

Key Concepts

1. Dementia.
2. Depression with features unique to various life cycle stages.
3. Functional disorders.
4. The role of anxiety with increased age and relations to later life depression.
5. The search for social and psychological causes of changes in functioning aside from physical problems.
6. Diagnosis/Assessment of the elderly client is discussed with introduction to the concepts of social history, environmental analysis, ADL, and caregiver analysis.
7. Appropriate use of neurological and psychiatric exams.
8. The importance of psychological testing to determine changes in memory and cognitive functioning.
9. Introduction to commonly used measuring instruments including tests for depression, cognitive functions, and functioning abilities.

NOTE: This is not all done in this week but is a continuing flow for the next three weeks in the course. The students understand that they are being introduced to these concepts and that further course work will be required for the kind of understanding necessary to utilize them in practice.

Learning Activities/Labs

Lecture, videotape, instrument examination, and discussion. In addition to viewing the assessment interview students have assessment tools to examine.

Suggested Readings

Zarit, Chp. 5: Psychopathology and behavioral assessment.

Zarit, Chp. 8: Depression.

Zarit, Chp. 9: Functional psychiatric problems.

Audiovisual Resources

Functional Assessment Inventory - "Interview", (videotape)

SESSION 6: MENTAL HEALTH PROBLEMS OF THE ELDERLY - DIAGNOSIS, TREATMENT, AND SUPPORT NETWORK AND SERVICES

Overview of Session Content

Emphasis is on further understanding of diagnostic issues plus an introduction to an eight-point framework for looking at treatment of the elderly. From a clinical assessment approach, the eight-point framework includes a review of pro's and con's and the implications of the following treatment concepts. An expanded view of treatment of mental health problems is emphasized.

Key Concepts

1. Medications: use and abuse.
2. Community services as a supportive network.
3. Individual therapy.
4. Family therapy.
5. Caregiver support network and caregiver treatment needs.

6. Appropriate use and nature of respite care.

7. Institutional care.

The importance of using all approaches, as appropriate, is emphasized since, as all professions know, the only treatment used consistently for many elderly is medication.

Learning Activities/Labs

Lecture and audio tapes.

A series of tapes which deals with understanding and coping with dementia, recognition and diagnosis of dementia and ongoing management and outcome of dementia is used to supplement classroom activity and delineate some real problems of the elderly.

Suggested Readings

Zarit, Chp. 6: Brain disorders in old age: Causes and assessment.

Zarit, Chp. 7: Physical assessment by Robert M. Tager, M.D.

Zarit, Chp. 13: Treatment of brain disorders.

Audiovisual Resources

Film series on dementia in three parts:

Part I: RECOGNITION AND DIAGNOSIS - Includes identifying sypmtoms and warning signs, the family's recognition of the problem, discussion of the medical and psychiatric evaluation of the patient, and illustrations of patient and family coping mechanisms.

Part II: ONGOING MANAGEMENT - Describes the care of the patient and the physician's role in providing family support. Psychosocial supports through community resources and family support groups along with the day-to-day home management of the patient are discussed.

Part III: COURSE AND OUTCOME - Winner, Silver Screen Award, U.S. Industrial Film Festival, 1985 - Focuses on issues of late care including institutional care alternatives, guidelines for nursing home placement, the physician's role in family decisions, dealing with death, dying and grief, and the caregiver's life following the loss of the loved one.

SESSION 7: INTERVENTION STRATEGIES: NETWORKS AND INTERVIEWING

Overview of Session Content

Two levels of activity happen at this point in the course. The didactic process continues but is supplemented by beginning experiential work by the class. At the didactic level, support networks are reviewed. Formal and informal support networks of elderly populations are important and need to be a part of the practitioner's knowledge base. The ubiquitous presence of informal support networks, whether in residential community settings, boarding homes, high rises, or other institutions, speaks for the adaptive capacity of people in late life. Knowledge of social networks is introduced as a part of the tool kit of the practitioner. A practitioner who is knowledgeable about the kinship and friendship support networks will be able to make a better intervention plan than if working only with formal community resources.

Mental health care or the lack thereof in nursing home settings is also introduced in this session because formal community resources for mental health services has little appeal to the nursing home industry. The focus is on pre-existing intra-institutional human resources for mental health care delivery by the practitioner. Discussion deals with not only the issue of mental health, but student attitudes about mental health and mental health in nursing homes.

A second part of the educational experience is introduced here with the discussion of interviews to be taped by students in the community. In almost every class, there will be some students who have never really talked to an older person except a relative, and there will be some people quite experienced in agency responsibilities.

Key Concepts

1. Informal social support networks are a part of the practitioners' tool kit.
2. Knowledge of the function of support networks is vital for practitioners in high migration areas.
3. Mental health in nursing homes is severely neglected.
4. Lower level nursing home staff can be valuable resources for planning institutional interventions.

Learning Activities/Labs

In several years of developing this early experience, we have found that using small group process begins to get the class working on their interpersonal skills. Groups of three or four students are optional in developing a very simple interview instrument. Once an interview instrument is completed, they are instructed to find older persons over 65 not known to them in the community, and convince them to do a taped interview. Session 7 is spent introducing the class to the group concept approach and to the beginning of the development of their interview instrument. The rules for the interview are simple, the instrument must be on a non-controversial topic. The interview is pre-tested by role playing in the class and the resulting tapes are played back and critiqued by faculty and students.

Suggested Readings

Zarit, Chp. 10: Principles of treatment: A model of community care.

SESSION 8: INTERVENTION STRATEGIES: COUNSELING THERAPIES

Overview of Session Content

The students are now ready for greater specificity in their discussion about some of the mental health approaches that have been introduced earlier. This session is also designed to give them a better base for understanding one of the courses that follows in this sequence called Mental Health Counseling I. Therefore, more extended explanation is given of the mental health process discussed earlier in the course. The goal is to provide a broad range of basic understanding of different treatment approaches. The use of live demonstration, simulation, or media is essential.

Key Concepts

1. Specific discussion of behavior modification.
2. Client centered approaches.
3. Cognitive therapy.
4. Crisis intervention counseling.
5. Supportive therapy.

Learning Activities/Labs

To make this session more realistic for the classes, it is important to introduce some demonstrations of therapeutic approaches. For this course, we use a behavioral approach to depression in a group setting and staff members from treatment oriented residential aging programs provide the demonstration.

Role playing is used to develop student skills for taping interviews in the community. At this point, some student resistances are encountered in terms of fears about getting the older person to actually talk to them and agree to the interview. Students are urged to assist each other in developing their approaches and finding appropriate target populations of older persons.

Suggested Readings

Zarit, Chp. 11: Individual treatment: Supportive, behavioral, and cognitive approaches.

SESSION 9: GROUP APPROACHES

Overview of Session Content

Systems theory as a foundation for group and family therapy is introduced. Types of group therapy and group work most commonly used with the elderly are examined, such as reminiscence with those who are depressed and reality orientation with those who have organic and/or functional disorders. The traditional notion of family therapy is expanded to fit with the families of the elderly. Therapy with adult children and other family members is explained. Marital relations and marital counseling for older couples in terms of the major issues for the later stages of life are presented. The use of teaching interventions (family life education) as a therapeutic tool is introduced and examples are provided.

The social context of aging and generational changes are integrated here so that students begin to understand that their assumptions about aging are often incorrect and need discussion, both in terms of cognitive development and in terms of understanding the emotional basis of some of their own beliefs and attitudes. Various support groups are discussed as well as some of the pro's and con's of such activities. Students are made aware that support group users are typically middle class and white, leaving a large number of people in racial and ethnic minority groups coping in some different way.

Another issue related to counseling practice includes sexuality and aging; this topic is introduced by a thirty minute videotape. Distinction is made between normal and pathological changes in sexual functioning. The film is used as a way of understanding differences in staff or practitioner perspectives on sexuality distinct from those of the elderly client. It also provides case examples and solutions to problems in sexuality and aging.

Key Concepts

1. Group therapies are discussed relative to the elderly population.
2. Family therapy and marital counseling.
3. Multiple therapeutic strategies are introduced.
4. The practitioner must be introspective relative to the emotional part of his/her beliefs and behaviors regarding mental health and aging.
5. Organized support groups are available in many communities but typically are white and middle class.
6. Sexuality is a topic that is often hidden from practitioners but which is highly significant to elderly clients.

Learning Activities/Labs

The session includes, toward the end, an experiential learning activity related to family counseling. Students are asked to disclose aspects of their family life such as how rules are enforced and how nudity is handled. Students first write responses on a form, which is followed by discussion with a partner and, then, group discussion. This experience helps students identify their own biases and provides startling information for some who assume all backgrounds are the same.

Suggested Readings

Zarit, Chp. 12: Group and family intervention.

Zarit, Chp. 14: Sexuality and aging.

Audiovisual Resources

Sexuality in Nursing Homes with Richard Ham, M.D., from the series: Mental Health Care in Nursing Homes. (28 min. 54 secs.)

SESSION 11-14: KNOWLEDGE INTEGRATION AND USE

Overview of Session Content

These sessions are used in an effort to increase student ability to organize and synthesize the information learned in the previous course sessions. The instructional approach relies heavily on experiential activities and basic skill development.

Key Concepts

1. Review of concepts introduced in course; elaboration and integration of concepts with attitudes and skills.
2. Communication exercise, with students going through a programmed interaction to learn about gathering information about people.
3. Non-verbal communication observed and discussed.
4. Group and individual role playing.
5. Beginning review of taped interviews, with feedback and discussion.

SESSION 15: COURSE SYNTHESIS

Overview of Session Content

By this point, students have completed the review of their taped interviews and have had a chance to review, discuss, and integrate concepts in the course as a final session. A panel is organized, and in this case, is composed of the course instructors, community practitioners, and administrators. The panel responds to student questions and interacts with one another on current issues.

Key Concepts

1. Mental health services expansion or contraction.
2. New treatment approaches and/or new programs in the community.
3. Interdisciplinary collaboration of mental health treatment.
4. Private Practice with the elderly.

Learning Activities/Labs

Panel presentation and discussion.

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AUDIOVISUAL RESOURCES

Contact the Suncoast Gerontology Center, University of South Florida Medical Center, Box MDC 50, Tampa, FL 33612 for the following audiovisual resources:

Functional Assessment Inventory Training.

Sexuality and Aging (from the "Mental Health in Nursing Homes" film series).

Understanding and Coping with Dementia: Part I - Recognition and Diagnosis.

Understanding and Coping with Dementia: Part II - Ongoing Management.

Understanding and Coping with Dementia: Part III - Course and Outcome.

Chapter 3

PHYSICAL CHANGE, BEHAVIOR AND AGING

Sue V. Saxon, Ph.D.
Department of Gerontology

COURSE DEVELOPMENT CONSULTANTS

Guillermo J. Dardano, M.D., Ph.D.
Psychiatrist, Residential Aging Program
Department of Aging and Mental Health
Florida Mental Health Institute

Mary Jean Etten, Ed.D., C.D.E.
Professor of Nursing
School of Nursing
St. Petersburg Junior College
and
Adjunct Lecturer
Department of Gerontology

GEY 6613

PHYSICAL CHANGE, BEHAVIOR AND AGING

Course Objectives

1. To introduce students to relevant basic knowledge of human anatomy and physiology
2. To familiarize students with basic concepts of age-related changes in organ systems of the body, common diseases/pathology associated with the aging process, and current information on selected pharmacological interventions useful with older adults
3. To help students better understand the behavioral implications of physical changes and age

Course Description

Content:

1. Normal physical and biological changes associated with aging. Age-related changes in the following organ systems: nervous, cardiovascular, respiratory, musculoskeletal, gastrointestinal, urinary, sensory, skin, endocrine-metabolic, reproductive.
2. Survey of diseases commonly associated with aging:
   (a) Neurological - dementia, dizziness, Parkinson's, stroke, TIA, tardive dyskinesia
   (b) Cardiovascular - myocardial infarction, aneurysm, hypertension, congestive heart failure, arrhythmias and conductive disturbances, angina and ischemic heart disease, valvular heart disease, peripheral vascular disease (arteriosclerosis, atherosclerosis, varicose veins,

thrombophlebitis)

(c) Respiratory - TB, chronic obstructive pulmonary disease (COPD), emphysema, pneumonia

(d) Musculoskeletal - rheumatoid arthritis, osteoarthritis, osteoporosis, bursitis, gout, Paget's disease, myalgia

(e) Geriatric dentistry and related health problems

(f) Gastrointestinal - hiatal hernia, gastritis, peptic ulcer, hernias, cholelithiasis, Diverticulosis

(g) Urinary - urinary tract infections, incontinence, renal failures

(h) Sensory - presbyopia, presbycusis, otitis media, labyrinthitis, tinnitus, Meniere's syndrome, conjunctivitis, cataracts, glaucoma, macular degeneration, diabetic retinopathy

(i) Skin - pruritus, eczema, neoplasms, decubitus ulcer

(j) Endocrine-metabolic - hypo- and hyperthyroidism, diabetes

(k) Reproductive - prostatic hypertrophy, vaginitis, relaxation of pelvic organs

(l) Other problems to be included - fatigue, headache, insomnia and sleep disturbances, vertigo

3. Common drugs, interactions and side effects. Examples of drug categories to be discussed: analgesics, tranquilizers, diuretics, sedatives and hypnotics, cardiac drugs, hypotensives, cathartics, electrolyte replacements, vasodilating agents, antidepressants, anticonvulsants, estrogens/androgens, anticoagulants, antihistamines.

4. Relevant information on substance abuse, alcoholism, and self-medication.

Course Design

For each system, present enough anatomy and physiology so students will understand normal functioning sufficiently to see the significance of normal aging on each system. Illustrate lessened reserve capacity in the body due to normal physical aging in each system. Emphasize there is much individual variation in the rate of aging, but slowness and need for pacing are characteristic of most, if not all of us, as we age. Description of pathology should include etiology, the nature of pathological changes, associated symptoms and, above all, the effects of pathology on the person psychosocially.

Course Requirements

Course requirements include two examinations (one in-class examination and a final take home examination). The take home examination contains integrative questions requiring students to know and understand course material and also be able to use it in a practical and applied manner. Allowing student to use texts, notes, and other resource material for the final exam reduces student anxiety over remembering terms, lists of functions, diseases, etc., and allows them to concentrate on applying knowledge and understanding the behavioral significance of physical changes and aging.

Students are also required to have on-going interaction with some older person(s) during the semester and keep an informal log or diary of their experiences and insights into the impact of physical changes on older persons' behaviors and life styles. Sharing these experiences in class is a useful technique. This is an S-U graded project to allow students maximal flexibility in what they do for the project.

Suggested Texts

Saxon, S.V. & Etten, M.J. (in press). *Physical change and aging*, (2nd ed). New York: Tiresias Press.

This book is concise, readable, and has an applied orientation. It was written for students who do not have basic science backgrounds. It includes normal age-related changes in all organ systems of the body as well as a brief description of the more prevalent pathologies associated with older adulthood.

Pizer, H. (Ed.) (1983). *Over fifty-five, healthy and alive*. New York: Van Nostrand Reinhold.

This book was also written for those without strong science backgrounds. Its emphasis is on diseases commonly associated with older age as well as other health-related topics.

These two books used together provide coverage of both normal age-related changes in all organ systems of the body and pathologies commonly associated with older age. For those with biological science backgrounds who would like more specific citations of research in the physiology of aging, the following two books are recommended as texts:

1. Whitbourne, S.K. (1985). *The aging body*. New York: Springer-Verlag.
2. O'Hara-Devereaux, M., Andrus, L., & Scott, C. (Eds.) (1981). *Eldercare*. New York: Grune and Stratton.

SESSIONS

SESSION 1: ORGANIZATION AND INTRODUCTION

Overview of Session Content

The first session is both organizational and an introduction to the content of the course. Students are asked to introduce themselves and indicate background course work and experience in gerontology so the instructor and other students will know background experiences of the group.

Course objectives, course requirements, texts and topics to be covered are reviewed. Because many students in the social sciences lack basic science background, it is necessary to stress that extensive knowledge of anatomy and physiology is not a necessary prerequisite for the course. Students need to understand the focus of this course is more on behavioral implications of age-related physical changes and pathology than on memorizing basic anatomy and physiology.

Introductory material presented during the first week includes:

(a) A discussion of aging as a complex process involving the interplay of biological, psychological, and social factors. (b) Implications of lessened reserve capacity as the major "normal" age-related physical change in the body and how it affects homeostatic equilibrium, stress, pacing schedules and the need for environmental modification. (c) A discussion of the stereotype that aging is synonymous with illness. Include definitions of health, illness, and quality of life. (d) Recognize that assessing the impact of age-related physical changes and/or pathology is difficult in older adults because of the likelihood of multiple pathology. Discuss difficulties in diagnosis and management, especially of multiple chronic diseases. Emphasize that disease often presents itself in older adults without textbook symptoms. It is therefore necessary for gerontologists to be alert to subtle behavior changes or to symptoms older adults mention. (e) Familiarize students with the basic organizational plan of the body: cells, tissues, organs, systems. (f) If desired, and if time permits, students may be exposed to some of the theories of biological aging: genetic mutation, error theory, accumulation, wear and tear, toxin and immunological theories are examples.

Key Concepts

1. Complexity of aging process - requires multidisciplinary study
2. Implications of lessened reserve capacity
3. Difficulty in differentiating "normal" from pathological change in organ systems
4. Impact of homeostasis and how it is modified with age
5. Psychological and behavioral significance of slowing, pacing and stress
6. Multiple pathology common in older adults complicates understanding behavior changes in older adults

Suggested Readings

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Whitbourne, S.K. (1985). The aging body. New York: Springer-Verlag.

Wolanin, M. (1984). Confusion and disorientation. In B. Steffl (Ed.), Handbook of gerontological nursing. (pp. 119-134). New York: Van Nostrand Reinhold.

Audiovisual Resources

Be Well: Health in the Later Years. (Film)
24 minutes, color, 1983.
Source: Churchill Films, 662 N. Robertson Blvd., Los Angeles, CA 90069
Discusses health in older adulthood, myths, positive preventive health care.

Gerontological Nursing Series (Films)
6 films, 30 minutes each, color, 1979.
Source: American Journal of Nursing Rental Library, c/o USCAN International, 110 W. Hubbard Street, Chicago, IL 60610
Discuss losses: family, home, friends; sensory losses; slowing of physical abilities.

Staying Alive: Wellness after 60. (Video)

28 minutes, color, 1985

Source: Spectrum Films, Inc., P.O. Box 801, Carlsbad, CA 92008

Discusses health maintenance in older age.

SESSIONS 2 & 3: THE MUSCULOSKELETAL SYSTEM, EXERCISE AND NUTRITION

Overview of Session Content

- Stress the significance of this system for mobility and independence.
- Discuss general anatomy of the skeleton: axial, appendicular, cartilage, ligaments, joints, bursa.
- Discuss various types of muscle.
- Review basic functions of the musculoskeletal system.
- Present in greater detail the age-related changes in muscle and bone and have students discuss behavioral implications of these changes. Include safety in the home and in the community.
- Musculoskeletal pathology of significance for behavior in older adults includes arthritis, gout, osteoporosis, osteomalacia, bursitis, Paget's disease, myalgia. For each of these, include a discussion of symptoms, effects, management, prevention, and possible impact on physical and psychological health.

Following musculoskeletal aging, include information on exercise for older adults:

- Stress the impact of use-disuse.
- Include cautions in exercise programs for older adults.
- Discuss the appropriate components: warm-up, aerobic, cool-down and

discuss why each of these is more necessary for the older person.

- Discuss the benefits of a regular systematic exercise program as part of life style in middle and older age.

If time permits, some basic information on nutrition may be included. Material presented includes cautions about fad diets, need for balanced diet, but with fewer calories, and consensus information on what constitutes proper nutrition in the later years.

Key Concepts

1. independence and mobility dependent on musculoskeletal system
2. impact of lessened reserve capacity
3. components of appropriate exercise program: warm-up, aerobic, cool-down
4. psychosocial implications of various musculoskeletal pathology
5. prosthetic environments

Learning Activities/Labs

1. Have students observe gait and postural changes in older adults - share in class or in written report.
2. Have students analyze a public building or home/apartment in terms of appropriateness for older adults. Discuss in class or use it as a mini-term paper. This exercise can also be used as a take-home final examination question.
3. As an optional exercise, have students tape their knees and/or elbows and move about with these restrictions - walking, stair climbing, sitting, etc.
4. Observe and evaluate an exercise program used with older adults.

Suggested Readings

Biegel, L. (Ed.). (1984). Physical fitness and the older person. Rockville, MD: Aspen Systems Corporation.

Cadigan, M. (1984). Nutrition and the elderly. In B.M. Steffl (Ed.), Handbook of gerontological nursing. (pp. 377-393). New York: Van Nostrand Reinhold.

Coblyn, J. & Abrams, D. (1981). The skeleton. In H. Pizer (Ed.), Over fifty-five, healthy and alive. (pp. 121-132). New York: Van Nostrand Reinhold.

Etten, M.J., Hall, D., & Traynor, C. (1983). Wealth of health - an exercise program for the elderly. Tampa: Suncoast Gerontology Center, University of South Florida Medical Center.

Freedman, M.L. & Ahronheim, J.C. (1985). Nutritional needs of the elderly: debate and recommendations. Geriatrics, 40, 45-59.

Goodman, C.E. (1985). Osteoporosis: Protective measures of nutrition and exercise. Geriatrics, 40, 59-70.

Hamerman, D. (1986). Rheumatic disorders. In I. Rossman (Ed.), Clinical geriatrics, (3rd ed.). (pp. 513-522). Philadelphia: J.B. Lippincott.

Jessup, L.E. (1984). The musculoskeletal and nervous systems. In B. Steffl (Ed.), Handbook of gerontological nursing. (pp. 207-218). New York: Van Nostrand Reinhold.

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Ringel, S.P. & Simon, D.B. (1983). Practical management of neuromuscular diseases in the elderly. Geriatrics, 38, 86-92.

Rubenstein, L.Z. & Robbins, A.S. (1984). Falls in the elderly: A clinical perspective. Geriatrics, 39, 67-78.

Simpson, W.E. (1986). Exercise: Prescriptions for the elderly. Geriatrics, 41, 95-100.

Spencer, H., Sontag, S.J., & Kramer, L. (1986). Disorders of the skeletal system. In I. Rossman (Ed.), Clinical geriatrics, (3rd ed.). (pp. 523-537). Philadelphia: J.B. Lippincott.

Stevens, M.B. (1983). Rheumatic disease: An overview of geriatric problems. Geriatrics, 38, 67-78.

Trolinger, J. & Daehler, D. (1981). Musculoskeletal system. In M. O'Hara-Devereaux, L.H. Andrus, & C.D. Scott (Eds.), Eldercare. (pp. 217-234). New York: Grune & Stratton.

Audiovisual Resources

Active People Over Sixty. (Film)

25 minutes, color, 1976.

Source: Gerontological Film Collection, Media Library, P.O. Box
12898, North Texas State University, Denton, TX 76203.

Discusses the importance of physical activity in older age.

Be Well: Physical Fitness in the Later Years. (Film)

20 minutes, color, 1983.

Source: Churchill Films, 662 N. Robertson Blvd., Los Angeles, CA 90069

Discusses exercise for disease prevention and health maintenance.

Health, Fitness and Leisure for a Quality Life. (Film)

20 minutes, color, 1979.

Source: AAHPERD, c/o Film Center, 6522 Sligo Pkway., Hyattsville, MD
20782.

SESSION 4: THE NERVOUS SYSTEM

Overview of Session Content

Session 4 includes basic information on the nervous system and age-related changes. Basic concepts of anatomy/physiology include types of neurons, components of the CNS and ANS. Briefly explain structure and function of the spinal cord, brain stem, midbrain, cerebellum and cerebrum. Discuss current information on neurotransmitters. Age-related changes in the nervous system having implications for behavior are discussed in a rather global manner.

Nervous system pathology to be included:

(a) Strokes: major strokes and TIA's; risk factors, etiology, symptoms, and rehabilitation.

(b) Parkinson's: etiology, symptoms, management; need for support for caregivers.

(c) Tardive dyskinesia: iatrogenic; similar to Parkinson's.

(d) Dementia: differentiate between delirium and dementia. Discuss possible causes of delirium and stress the importance of recognizing such causal factors in behavior. Discuss the two major types of dementia, multi-infarct and senile dementia of Alzheimer's type. Include information on the difficulty of differential diagnosis.

Key Concepts

1. General function of spinal cord, brainstem, midbrain, cerebellum, cerebrum
2. Role of neurotransmitters
3. Impact of slowing on behavior
4. Difficulty in differentiating between delirium and dementia
5. Psychosocial implications of neurological dysfunctions

Learning Activities/Labs

Interview health care professionals about difficulties in managing stroke victims, those with Parkinson's and those with Alzheimer's disease.

Suggested Readings

Burnside, I.M. (1984). Organic mental disorders. In B. Steffl (Ed.), Handbook of gerontological nursing. (pp. 107-118). New York: Van Nostrand Reinhold.

Busby, J., Bonelli, A., Vargas, L., Stirna, J., & Caranosos, G. (1985). Alzheimer's disease: An annotated bibliography of recent literature. *J. Amer. Geriats. Soc.*, *33*, 366-373.

Carter, A.B. (1986). The neurologic aspects of aging. In I. Rossman (Ed.), *Clinical geriatrics*, (3rd ed.). (pp. 326-351). Philadelphia: J.B. Lippincott.

Fonda, D. (1985). Parkinson's disease in the elderly: Psychiatric manifestations. *Geriatrics*, *40*, 109-114.

Gilmore, R. (1984). Movement disorders in the elderly. *Geriatrics*, *39*, 65-76.

Greer, M. (1985). Recent developments in the treatment of Parkinson's disease. *Geriatrics*, *40*, 34-41.

LaRue, A., Dessonville, C., & Jarvik, L.F. (1985). Aging and mental disorders. In J. E. Birren & K.W. Schaie (Eds.), *Handbook of the psychology of aging*, (2nd ed.). (pp. 664-702). New York: Van Nostrand Reinhold.

Newman, R.P. & Calne, D.B. (1984). Diagnosis and management of Parkinson's disease. *Geriatrics*, *39*, 87-96.

Podlone, M. & Millikan, C.H. (1981). Neurology. In M. O'Hara-Devereaux, L.H. Andrus, & C.D. Scott (Eds.), *Eldercare*. (pp. 115-134). New York: Grune & Stratton.

Ross, Vivian & Robinson, B. (1984). Dizziness: Causes, prevention, and management. *Geriatric Nursing*, *Sept/Oct.*, 290-304.

Severson, J.A. (1984). Neurotransmitter receptors and aging. *J. Amer. Geriats. Soc.*, *32*, 24-27.

Wolanin, M. & Steffl, B.M. (1984). Neurological disorders of the elderly. In B. Steffl (Ed.), Handbook of gerontological nursing. (pp. 303-318). New York: Van Nostrand Reinhold.

SESSIONS 5 & 6: SENSORY SYSTEMS

Overview of Session Content

Following the introduction to the nervous system, sensory systems are presented with heavy emphasis on the psychological or behavioral implications of sensory changes in later adulthood.

- Lecture focus is on the gradual onset of sensory changes starting in middle age and ways in which people cope and adapt to changes as they occur. Often sensory changes do not limit activity unduly until the 70's or later.
- Discuss each of the sensory systems: (a) normal anatomy/physiology so students understand normal functioning; (b) age-related changes in each system; (c) behavioral implications of age-related sensory changes; (d) common pathology, especially in vision and audition.

If time and interest permit, information on the effects of sensory deprivation may be included. Information on the effects of enhanced sensory stimulation for older adults may also be appropriate here to stimulate students to think about possible effects of reduced sensory input.

- Pathology: Discuss symptoms, management, and psychosocial impact of pathology in vision and audition. Empirical data on taste, touch, and smell are somewhat contradictory, so the focus of discussion is usually on vision and hearing.
- Vision: cataract, glaucoma, macular degeneration, diabetic

retinopathy. (Presbyopia is included in the "normal" changes.)

- Audition: otitis media, tinnitus, Meniere's syndrome. (Presbycusis is included in the "normal" changes.)

Key Concepts

1. Impact of gradual sensory changes
2. Vision and hearing are major senses in our culture; taste, touch and smell are more minor senses
3. Virtually all information needed for problem solving, coping and adapting comes to us through sensory modalities
4. Individual variation in response to sensory impairments
5. Psychosocial implications of reduced sensory input

Learning Activities/Labs

Have students put cotton in their ears, dim the lights and have them try to understand lecture material presented in a soft voice with small handwriting on the chalk board. Share feelings with each other about reactions.

Other exercises are suggested in the various manuals on sensory deprivation.

Suggested Readings

Anderson, R.G., Simpson, K., & Roeser, R. (1983). Auditory dysfunction and rehabilitation. Geriatrics, 38, 101-112.

Berson, F.G. (1986). The eye in old age. In I. Rossman (Ed.), Clinical geriatrics, (3rd ed.). (pp. 403-409). Philadelphia: J.B. Lippincott.

Eifrig, D.E. & Simons, K.B. (1983). An overview of common geriatric ophthalmologic disorders. Geriatrics, 38, 55-77.

Ernst, M. & Shore, H. (1975). *Sensitizing people to the processes of aging: The in-service educator's guide*. Denton: Center for Studies in Aging, North Texas State University.

Goodhill, V. (1986). Deafness, tinnitus, and dizziness in the aged. In I. Rossman (Ed.), *Clinical geriatrics*, (3rd ed.). (pp. 410-423). Philadelphia: J.B. Lippincott.

Hickey, T. & Fatula, B. (1975). *Sensory deprivation and the elderly*. University Park: The Gerontology Center, Pennsylvania State University.

Kline, D.W. & Schieber, F. (1985). Vision and aging. In J.E. Birren & K.W. Schaie (Eds.), *Handbook of the psychology of aging*, (2nd ed.). (pp. 296-331). New York: Van Nostrand Reinhold.

Mader, S. (1984). Hearing impairment in elderly persons. *J. Amer. Geriats. Soc.*, *32*, 548-553.

McCann, J., Rodnick, J., & Rubin, R.J. (1981). Problems of the ears, nose, and throat. In M. O'Hara-Devereaux, L.H. Andrus, & C.D. Scott (Eds.), *Eldercare*. (pp. 247-258). New York: Grune & Stratton.

Ochs, A.L., Newberry, J., Lenhardt, M.L., & Harkins, S.W. (1985). Neural and vestibular aging associated with falls. In J.E. Birren & K.W. Schaie (Eds.), *Handbook of the Psychology of aging* (2nd ed.). (pp. 378-399). New York: Van Nostrand Reinhold.

Olsho, L.W., Harkins, S.W., & Lenhardt, M.L. (1985). Aging and the auditory system. In J.E. Birren & K.W. Schaie (Eds.), *Handbook of the psychology of aging*, (2nd ed.). (pp. 332-377). New York: Van Nostrand Reinhold.

Ordy, J.M. & Brizzee, K.R. (Eds.). (1979). *Sensory systems and communication in the elderly*. New York: Raven Press.

Rupp, R. & Jackson, P.D. (1986). Primary care for the hearing impaired: A changing picture. *Geriatrics*, *41*, 75-84.

Steffl, B. (1984). Sensory deprivation in the elderly. In B. Steffl (Ed.), *Handbook of gerontological nursing*. (pp. 50-66). New York: Van Nostrand Reinhold.

Taisch, E.A., Taish, D.A., & Metz, H.S. (1981). Problems of the eyes. In M. O'Hara-Devereaux, L.H. Andrus, & C.D. Scott (Eds.), *Eldercare*. (pp. 259-276). New York: Grune & Stratton.

Audiovisual Resources

Hearing Loss in the Elderly. (Film)

37 minutes, color, 1980

Source: Speech & Hearing Sciences, University of Washington,
1417 N.E. 42nd Street, Seattle, WA 98195.

Explains types of hearing loss, hearing aids, and techniques useful for those with hearing impairment.

The Sixth Sense. (Video)

27 minutes, color, 1985

Source: EXAR Communications, 117 Sharpe Avenue, Staten Island, NY 10302.

Discusses sensory changes and aging.

Aging: Sensory Losses (Video)

30 minutes, color, 1980

Source: The American Journal of Nursing, c/o Educational Services Division, 555 W. 57th Street, New York, NY 10019.

Discusses practical suggestions to help older adults compensate for sensory losses.

Our Aging Senses: Maintaining a Quality of Life. (slide/audiocassette)

14 minutes, color, 1983

Source: Ross Laboratories, 585 Cleveland Avenue, Columbus, OH 43216.

Overview of sensory changes with age and discusses how to assist older adults to adapt to sensory change.

SESSIONS 7 & 8: CIRCULATORY SYSTEM

Overview of Session Content

Due to the complexity and extent of circulatory changes and pathology, two sessions are devoted to understanding basic anatomy/physiology of the heart and blood vessels, age-related changes, and common pathology in this system.

- Discuss structure of the heart and normal heart function.
- Discuss structure of the blood vessels and function, including blood pressure. Discuss systemic and pulmonary circulation. Students need to understand basic principles of how blood is delivered to body cells for them to interpret the significance of pathology if it occurs.
- Discuss blood pressure: what it represents, how measured, range of

"normal" blood pressure; factors affecting it.

- Discuss "normal" age-related changes in cardiovascular system.

Pathology to be included:

- Arteriosclerosis and atherosclerosis.
- Hypertension: hypertension medications, controversy over definition of hypertension in the elderly.
- Other pathology to consider: aneurysm, phlebitis, varicose veins, arrhythmias, valvular disease, angina, congestive heart failure, and myocardial infarction.
- Discuss with students psychosocial factors in heart disease: anxiety, the cardiac cripple, family reactions (over-protectiveness, for example). Have them discuss how these pathologies might influence life style.

Key Concepts

1. Heart is a very efficient double pump - action must be coordinated
2. Significance of age-related changes for efficiency of heart and fatigability of older adults
3. Difficulty in defining hypertension in older age
4. Impact of cardiovascular pathology on psychosocial functioning of individuals

Learning Activities/Labs

Interview older adults who have cardiovascular pathology. Discuss psychological and physical implications for life styles.

Suggested Readings

Fleg, J.L. & Lakatta, E.G. (1986). Cardiovascular disease in old age. In I. Rossman (Ed.), Clinical geriatrics, (3rd ed.). (pp. 169-196). Philadelphia: J.B. Lippincott.

Fowkes, W.C. & Fowkes, V. (1981). Cardiovascular system. In M. O'Hara-Devereaux, L.H. Andrus, & C.D. Scott (Eds.), Eldercare. (pp. 149-168). New York: Grune & Stratton.

Knudsen, F.S. (1984). Cardiovascular conditions in older adults. In B. Steffl (Ed.), Handbook of gerontological nursing. (pp. 221-233). New York: Van Nostrand Reinhold.

Pulliam, J.P. & McCarron, D.A. (1984). Hypertension: Special concerns in geriatric patients. Geriatrics, 39, 34-40.

Steinberg, F.U. (1986). Rehabilitating the older stroke patient: What's possible? Geriatrics, 41, 85-97.

SESSION 9: RESPIRATORY SYSTEM

Overview of Session Content

System may be divided into conducting division and respiratory division. Discuss components of each and process of respiration.

- Discuss "normal" age-related changes in the system. Stress the fatigability usually associated with lessened efficiency of the system. Relate to circulatory changes as well.
- Pathology: include COPD, pneumonia, tuberculosis and lung cancer.
- Emphasize the anxiety associated with breathing disorders and need for family support and understanding.

Key Concepts

1. Age-related changes in respiratory system and increased fatigability in older age.
2. Respiratory changes and circulatory system changes are closely interrelated
3. Psychological impact of respiratory impairments
4. Need for education and support for individual and family

Learning Activities/Labs

Interview older adults with respiratory problems and/or discuss implications of respiratory disease with health care professionals. Share in class.

Suggested Readings

Agle, D.P. & Baum, G.L. (1977). Psychological aspects of COPD. *Medical clinics of North America*, *61*, 749-758.

Anderson, W.M., Ryerson, G.G., & Wynne, J.W. (1986). Pulmonary disease in the elderly. In I. Rossman (Ed.), *Clinical geriatrics*, (3rd ed.). (pp. 230-259). Philadelphia: J.B. Lippincott.

Kerson, T.S. & Kerson, L.A. (1985). *Understanding chronic illness*. (pp. 187-219). New York: The Free Press.

Knudsen, F.S. (1984). Respiratory conditions in older adults. In B. Steffl (Ed.), *Handbook of gerontological nursing*. (pp. 251-258). New York: Van Nostrand Reinhold.

Parsons, G.H., White, L., & Lillington, G.A. (1981). Respiratory. In M. O'Hara-Devereaux, L.H. Andrus, & C.D. Scott (Eds.), *Eldercare*. (pp. 189-198). New York: Grune & Stratton.

SESSIONS 10 & 11: GASTROINTESTINAL SYSTEM

Overview of Session Content

Discuss structure and normal functioning. Discuss age-related changes in the mouth, esophagus, stomach, and intestine. Include behavioral significance of these changes for older adults. GI system is the focus of many complaints, but tends to function more effectively in older age than many other systems. Discuss the impact of cultural stereotypes on older adults' expectations and beliefs about GI functioning. For example, constipation is more associated with poor eating habits and sedentary life style than with age. Emphasize the role of emotional factors in GI functioning.

- Pathology to include: dysphagia, hiatus hernia, gastritis and ulcer, constipation and diarrhea, colitis, diverticulosis, cholelithiasis, cancer.
- Discuss dental care in elderly and possible relationship to diet.

Key Concepts

1. GI system does not change dramatically with age
2. Impact of stereotypes and folklore regarding aging of the GI system
3. Need for more education about GI aging
4. Impact of life style factors
5. Significance of dental care and relationship to nutrition

Suggested Readings

Brandt, L.J. (1986). Gastrointestinal disorders in the elderly. In I. Rossman (Ed.), Clinical geriatrics, (3rd ed.). (pp. 260-277). Philadelphia: J.B. Lippincott.

Eastwood, G.L. (1984). GI problems in the elderly. Geriatrics, 39, 59-82.

Knudsen, F.S. (1984). Gastrointestinal and metabolic problems in older adults. In B. Steffl (Ed.), Handbook of gerontological nursing. (pp. 234-250). New York: Van Nostrand Reinhold.

Morgan, W., Thomas, C., & Schuster, M. (1981). Gastrointestinal. In M. O'Hara-Devereaux, L.H. Andrus, & C.D. Scott (Eds.), Eldercare. (pp. 199-216). New York: Grune & Stratton.

SESSION 12: URINARY SYSTEM

Overview of Session Content

Discuss the significance of this system for maintaining homeostasis. Kidney function especially essential for life. Outline and briefly discuss components of urinary system and normal functioning. Discuss age-related changes with strong emphasis on psychosocial implications for behavior (incontinence, for example).

- Pathology: Include discussion of incontinence, urinary tract infections, renal failure. Include symptoms, possible prevention, and psychological implications.

Key Concepts

1. Relationship to circulatory system
2. Significance of urinary system for homeostasis
3. Psychosocial impact of age-related changes

Suggested Readings

Burton, J.R. (1984). Managing urinary incontinence - A common geriatric problem. Geriatrics, 39, 46-62.

Feinstein, E.I. (1986). Renal disease in the elderly. In I. Rossman (Ed.). Clinical geriatrics, (3rd ed.). (pp. 215-229). Philadelphia: J.B. Lippincott.

Freed, S.Z. (1986). Genitourinary disease in the elderly. In I. Rossman (Ed.), Clinical geriatrics, (3rd ed.). (pp. 352-363). Philadelphia: J.B. Lippincott.

Knudsen, F.S. (1984). Genitourinary and gynecological problems of older adults. In B. Steffl (Ed.), Handbook of gerontological nursing. (pp. 259-271). New York: Van Nostrand Reinhold.

Judson, L., Novotny, T., McAninch, J., & Scott, J.C. (1981). Genitourinary system. In M. O'Hara-Devereaux, L.H. Andrus, & C.D. Scott (Eds.), Eldercare. (pp. 169-188). New York: Grune & Stratton.

SESSION 13: SKIN, REPRODUCTIVE AND ENDOCRINE SYSTEMS

Overview of Session Content

Because of less available data and perhaps fewer psychosocial implications, skin, reproductive and endocrine systems are briefly presented in session 13.

Skin

Discuss layers, functions, and normal aging changes. Emphasize cultural stereotypes of beauty make psychological implications of skin changes more significant than the actual physical changes and their impact on health. Skin changes are the overt markers of aging.

Stress the significance of proper foot care in the elderly, especially cutting toenails.

- Pathology

  Include skin cancers, decubitus ulcers, and pruritus.

Reproductive system

Briefly discuss male and female reproductive organs, function and normal aging changes. Discuss psychological implications of climacteric changes for both men and women. Discuss sexuality and physical change and influence of stereotypes.

- Pathology - prostatic hypertrophy, vaginitis, relaxation of pelvic organs.

Endocrine system

Relatively little is known about aging and the endocrine system. Discuss the major glands, locations and general functions. The aging process impairs the efficiency of endocrine function somewhat, but need more research in this area.

Significance for homeostatic equilibrium.

- Pathology

  Include hypo- and hyperthyroidism; diabetes.

Key Concepts

1. Psychological significance of age-related skin changes
2. Functional significance of proper foot care, a relatively neglected part of health care
3. Psychological impact of age-related changes in the reproductive system
4. Significance of endocrine functioning for homeostasis

Learning Activities/Labs

Talk to middle aged and older persons about the personal impact of skin changes. Discuss standards of beauty. Share in class.

Suggested Readings

Albin, J., Ross, H., & Rifkin, H. (1986). Diabetes in the elderly. In I. Rossman (Ed.), Clinical geriatrics, (3rd ed.). (pp. 629-640). Philadelphia: J.B. Lippincott.

Davis, P.J. & Davis, F.B. (1986). Endocrine diseases. In I. Rossman (Ed.), Clinical geriatrics, (3rd ed.). (pp. 424-437). Philadelphia: J.B. Lippincott.

Gilchrest, B.A. (1986). Dermatologic disorders in the elderly. In I. Rossman (Ed.), Clinical geriatrics, (3rd ed.). (pp. 375-387). Philadelphia: J.B. Lippincott.

Jessup, L.E. (1984). The integument. In B. Steffl (Ed.), Handbook of gerontological nursing. (pp. 173-178). New York: Van Nostrand Reinhold.

Robinson, J.K. (1983). Skin problems of aging. Geriatrics, 38, 57-65.

Steffl, B.M. (1984). Sexuality and aging. In B. Steffl (Ed.), Handbook of gerontological nursing. (pp. 450-464). New York: Van Nostrand Reinhold.

Sundwall, D.N., Rolando, J., & Thorn, G.W. (1981). Endocrine and metabolic. In M. O'Hara-Devereaux, L.H. Andrus, & C.D. Scott (Eds.), Eldercare. (pp. 135-148). New York: Grune & Stratton.

Walther, R.R. & Harber, L.C. (1984). Expected skin complaints of the geriatric patient. Geriatrics, 39, 67-80.

SESSIONS 14 & 15: PHARMACOLOGY AND PAIN CONTROL

Overview of Session Content

The final two sessions are devoted to pharmacology and pain control.

Pharmacology

Discuss the concept of compliance: definition, reasons for compliance or non-compliance in older adults. Significance of polypharmacy in the elderly. How and why drugs may affect older adults differently than younger persons.

- Physical changes: body mass, pharmacokinetics for example
- LADME system: liberation, absorption, distribution, metabolism, and elimination.
- Sensory changes and effect on medication regimes
- Psychosocial factors affecting drug usage: knowledge-education, anxiety, depression, grief, personal fable, mobility
- Briefly discuss categories of common drugs and where to obtain accurate information

Pain control

- Discuss medications and effects
- pain control centers and techniques: hypnosis, biofeedback, TENS, relaxation, family involvement, etc.

Finish the course with upbeat discussion of health maintenance, wellness, fitness, etc.

Key Concepts

1. What compliance means; use and misuse of the term
2. Significance of polypharmacy and relationship to psychological functioning
3. LADME: changes in older adults
4. Impact of lack of knowledge and stereotypes on medication regimens
5. Need for pain control education in older adults

6. Types of pain control procedures

7. New emphasis on wellness and significance for older adults

Learning Activities/Labs

Interview older adults about their health maintenance activities and life styles. Share in class. Read popular magazines or watch TV for health information directed to the older population. Compile a notebook of current advice/programs for wellness behavior in older age.

Suggested Readings

Burdman, G.M. (1986). Healthful aging. Englewood Cliffs: Prentice-Hall.

Carruthers, S.G. (1986). Principles of drug treatment in the aged. In I. Rossman (Ed.), Clinical geriatrics, (3rd ed.). (pp. 114-124). Philadelphia: J.B. Lippincott.

Cooper, J.W. (1981). Pharmacology: Drug-related problems of the elderly. In M. O'Hara-Devereaux, L.H. Andrus, & C.D. Scott (Eds.), Eldercare. (pp. 65-82). New York: Grune & Stratton.

Creighton, J.L. & Dychtwald, K. (1981). Alternative therapies and management of stress and catastrophic diseases. In M. O'Hara-Devereaux, L.H. Andrus, & C.D. Scott (Eds.), Eldercare. (pp. 307-318). New York: Grune & Stratton.

Johnson, J. & Pawlson, L. (1981). Health maintenance. In M. O'Hara-Devereaux, L.H. Andrus, & C.D. Scott (Eds.), Eldercare. (pp. 293-306). New York: Grune & Stratton.

Naeger, L. (1983). Substance abuse. In N. Ernst & H.G. Waldman (Eds.), The aged patient. (pp. 125-141). Chicago: Yearbook Medical Publishers.

O'Hara-Devereaux, M. & Andrus, L.H. (1981). Approach to pain management in elders. In M. O'Hara-Devereaux, L.H. Andrus, & C.D. Scott (Eds.), Eldercare. (pp. 319-328). New York: Grune & Stratton.

Pagliaro, L. & Pagliaro, A.M. (Eds.). (1983). Pharmacologic aspects of aging. St Louis: C.V. Mosby.

Poe, W.D. & Holloway, D.A. (1980). Drugs and the aged. New York: McGraw-Hill.

Rowe, J.W. & Besdine, R.W. (1982). Drug therapy. In J.W. Rowe & R.W. Besdine (Eds.), Health and disease in old age. (pp. 39-53). Boston: Little, Brown.

Sheridan, E.S. (1984). Drugs and the elderly. In B. Steffl (Ed.), Handbook of gerontological nursing. (pp. 394-424). New York: Van Nostrand Reinhold.

Simonson, W. (1984). Medications and the elderly. Rockville, MD: Aspen Systems Corporation.

Audiovisual Resources

Sources from session I may also be appropriate here.

REFERENCES

Abrahams, J.P. & Crooks, V.J. (1984). Geriatric mental health. Orlando: Grune and Stratton.

Adams, G. (1977). Essentials of geriatric medicine. New York: Oxford.

Beasley, D. & Davis, G.A. (Eds.). (1981). Aging - Communication processes and disorders. New York: Grune and Stratton.

Birren, J. & Schaie, K. (Eds.). (1985). *Handbook of the psychology of aging* (2nd ed). New York: Van Nostrand Reinhold Company.

Blumenthal, H.T. (Ed.). (1983). *Handbook of diseases of aging*. New York: Van Nostrand.

Brocklehurst, J.C. (Ed.). (1985). *Textbook of geriatric medicine and gerontology* (2nd ed.). New York: Churchill Livingstone.

Brody, E.M. (1985). *Mental and physical health practices of older people*. New York: Springer.

Busse, E.W., & Blazer, D.G. (Eds.). (1980). *Handbook of geriatric psychiatry*. New York: Van Nostrand Reinhold.

Cape, R., Coe, R.M., & Rossman, I. (Eds.). (1982). *Fundamentals of geriatric medicine*. New York: Raven Press.

Denham, M. (Ed.). (1980). *The treatment of medical problems in the elderly*. Baltimore, MD: University Park Press.

Edinberg, M. (1985). *Mental health practice with the elderly*. Englewood Cliffs: Prentice-Hall, Inc.

Ernst, N. & Glazer, D. (Eds.). (1983). *The aged patient: A sourcebook for the allied health professional*. Chicago: Yearbook Medical Publishers.

Ernst, M. & Shore, H. (1976). *Sensitizing people to the processes of aging: The in-service educator's guide*. Denton: North Texas State University, Center for Studies in Aging.

Exton-Smith, A.N. & Overstall, P.W. (1979). *Geriatrics*. Baltimore, MD: University Park Press.

Finch, C. & Schneider, E.L. (Eds.). (1985). *Handbook of the biology of aging*. New York: Van Nostrand Reinhold Company.

Fleming, R.E., Green, S.E., & Rich, T.A. (1982). In-service training in gerontology: A case study of statewide needs assessment. *Educational Gerontology*, *8*, 63-74.

Griffin, L.W. & Gottesman, L.E. (1983). Training professionals in aging and mental health. In M.A. Smyer & M. Gatz (Eds.), *Mental health and aging*. Beverly Hills, CA: Sage Publications.

Hickey, T. & Fatula, B. (1975). *Sensory deprivation and the elderly*. University Park: The Gerontology Center, Pennsylvania State University.

Johnson, H.R., Britton, J.H., Lang, C.A., Seltzer, M.M., Stanford, E.P., Yancik, R., Maklan, C.W., & Middleswarth, A.B. (1980). Foundations for gerontological education. *The Gerontologist*, *20*(3-11), 1-61.

Kane, R.L., Ouslander, J.G., & Abrass, I.B. (1984). *Essentials of clinical geriatrics*. New York: McGraw Hill.

Kermis, M. (1986). *Mental health in late life*. Boston: Jones & Bartlett.

Lesnoff-Caravaglia, G. (Ed.). (1980). *Health care of the elderly: Strategies for prevention and intervention*. New York: Human Sciences Press.

Libow, L.S. & Sherman, F.T. (Eds.). (1981). *The core of geriatric medicine*. St. Louis: C.V. Mosby.

Maletta, G. & Pirozzolo, F. (Eds.). (1980). *The aging nervous system*. New York: Praeger.

O'Hara-Devereaux, M., Andrus, L., Scott, C. & Gary, M. (Eds.). (1981) *Eldercare - A practical guide to clinical geriatrics*. New York: Grune and Stratton.

Ordy, J.M. & Brizzee, K.R. (Eds.). (1979). *Sensory systems and communications in the elderly*. New York: Raven Press.

Pfeiffer, E. (1975). Psychopathology and social pathology. In J. Birren & K. Warner Schaie (Eds.), *Handbook of the psychology of aging*. New York: Van Nostrand Reinhold Company.

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SLIDES & AUDIOTAPES

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VIDEOTAPES

Age-related sensory losses. Visual changes in the older adult. Touch, taste and smell changes. Hearing changes in the elderly. All available from the University of Michigan.

Chapter 4

PSYCHOPATHOLOGY AND AGING I

Larry W. Dupree, Ph.D.
Chair, Department of Aging and Mental Health
Florida Mental Health Institute

Victoria K. Dunn, M.A.
Center for Applied Gerontology
and
Department of Clinical/Community Psychology

GEY 6614

PSYCHOPATHOLOGY & AGING I

Course Objectives

1. To understand the developmental nature of mental health/mental illness in our culture
2. To examine models for understanding abnormal age-related behavior and to gain familiarity with current personality theories and/or explanations for abnormal behavior of older adults
3. To better understand the influences that contribute to labeling older individuals, as well as the purposes and methods of assessing older adults
4. To examine common mental health issues associated with aging, and the relationship between coping skills and mental health
5. To recognize conditions not attributable to a mental health disorder that may become a focus of mental health attention or treatment in later life

Course Description

Content:

1. Introduction: History and Scientific Considerations
    a. History of psychopathology and aging
    b. Criteria of mental health and implications for the older adult
    c. Models for understanding "abnormal" aging-related behavior in older adults
    d. Personality theories as explanations for abnormal behavior in older adults

2. Classification and Assessment of Older Adults
    a. Issues in classification of abnormal behavior
    b. Consistency and variability of behavior -- can behavior be summarized (diagnosed) with reliability and validity?
3. Mental Health Issues Associated with Age
    a. Common stressors which affect the mental health of older adults
    b. Common issues of loss and change in normal aging
    c. Coping strategies
    d. Relationship between coping and mental health
    e. Conditions not attributable to a mental disorder that are sometimes a focus of mental health attention/treatment (V codes in DSM-III)
4. The Relationship of the Discussed Personality Theories and Models to Aging Behavior
    a. The Explanatory Utility of Each Theory
    b. The Explanatory Utility of Each Model
    c. The Relationship of Each Model to Its Underlying Theory(ies)

Course Design

This course is characterized by didactic instruction but also features films in which the originators of theories of personality elaborate on their systems. Approximately 70 percent of class time is devoted to lectures and class discussion. The non-lecture portion features films and comparisons of how different systems explain aging-related behaviors. An attempt is made to impress upon students that "explanatory" models and personality theories are functions both of the era in which they were generated and life experiences of the theorist. Most class sessions have readings from a required text as well as articles. Examinations occur at mid-term and at the end of the course (final), and consist of multiple-choice items.

Course Requirements

Course requirements consist of required classroom attendance, reading assignments, and testing as indicated above.

SESSIONS

SESSION 1: INTRODUCTION TO PSYCHOPATHOLOGY AND AGING

Overview of Session Content

The first class week provides an introduction to the content and format of the course. The course objectives, topics, and requirements are reviewed. It is important to share the instructor(s)' background and experience, as well as perspective, in the area of mental health. Similarly, the class participants should be asked to describe their own background in mental health and aging. Knowing the range of education and experience in the group helps keep the course on target. This course can stand alone, but is intended as a complement, if not a prerequisite, to Psychopathology and Aging II.

After the introduction, the session moves into a brief overview of the history of psychopathology, and a discussion of the recent interest in psychopathology and aging. The review/overview moves from abnormal behavior as being initially associated with demonic origins to more recent classification systems.

In addition to historical considerations, scientific considerations regarding personality theory and its development are discussed. Included is the point that there is no single concept of personality, that theories vary in their explanations of abnormal behavior, and that some have more research support than others. It should be pointed out that all in the room have their "system" for explaining behavior, and that this course offers an opportunity to review that system. Also elaborated are the functions of a personality theory and the framework to be used in comparing theories in this course. Theories are to be compared across relevant elements: structure, developmental, motivational, abnormal conditions, and therapeutic approaches.

Key Concepts

1. Historical considerations of abnormal behavior
2. The evolution of rudimentary classification systems
3. Every theory of personality or behavior is a product both of its time and of the life experiences of its creator and proponents.
4. Scientific considerations of abnormal behavior
5. There is no single concept of personality.
6. Three assumptions in any personality theory
7. Functions of a personality theory
8. Framework for comparing theories

Suggested Readings

Gatchel & Mears, Chp. 1: Personality: An introduction.

Gatchel & Mears, Chp. 2: Overview of personality theories and assessment.

SESSION 2: PERSONALITY THEORIES AS EXPLANATIONS FOR BEHAVIOR: CLASSICAL PSYCHOANALYTIC THEORY

Overview of Session Content

By discussing four major periods in Freud's life, it can be demonstrated that classical psychoanalytic theory is a result of Freud's training, culture and era. The review of Freud's theory begins with the structural elements: a) the topographic model, and b) the id, ego, and superego. Second to be discussed are the motivational elements: the instincts (Eros and Thanatos), instinct location, instincts as sources of energy and object cathexis-anticathexis. Third to be discussed are the psychosexual stages, or developmental elements. Abnormal elements are discussed in terms of psychosexual stage fixation (and regression under stress), anxiety (a major concept in Freudian theory), and ego-defense mechanisms. Therapeutic elements, in terms of "the talking cure" and a classical psychoanalytic perspective are discussed.

The meaning of mental health or maturity in Freud's system should also be discussed as well as whether the Freudian view is conducive to working with the elderly. The classical psychoanalytic view notes that as age increases there is a reduction in energy for change and too much history to overcome. Freud saw little hope (relative to personality/behavior change) for the elderly and the mentally deficient. Other Freudian views biased against older adults center on:

a) the origins of behavior (and thus behavior change) or internal agents versus environmental stressors/influences.

b) the fixed nature of behavior after just a few years of life.

c) psychic determinism - ideas and ways of thinking are determined by past mental events.

Key Concepts

1. Classical psychoanalytic theory
2. Topographic model (conscious, preconscious, unconscious aspects of cognitive behavior)
3. Id, ego, superego: pleasure principle, reality principle, conflict, ego-defense mechanisms
4. Major instincts as sources of energy: Eros and Thanatos
5. Psychosexual (developmental) stages
6. Bases for inappropriate behavior in Freud's system
7. The definition of mental health or maturity in Freud's system

Suggested Readings

Gatchel and Mears, Chp. 3: Classical psychoanalysis.

SESSION 3: PERSONALITY THEORIES AS EXPLANATIONS FOR BEHAVIOR: HEINZ HARTMAN AND ERIK ERIKSON

Overview of Session Content

A discussion of Hartman should point out the transition from the "Id psychology" of Freud to further development of the role of the ego. This move undermined the primacy of the id and led to the emergence of ego psychology. As the role of the ego was dramatically enlarged, it included operations other than conflict resolution. The new focus now includes cognitive functions. The structural elements of Hartman are the id, ego, and superego, with the ego playing the most important role. Behavior is motivated (motivational elements) by inherited ego apparatuses as well as instincts. The goal of behavior is adaption to the environment, the social milieu (rather than solely meeting instinctual need). In Hartman's system, development is not in psychosexual stages, but rather in terms of the changing functions of the ego so as to effectively cope with the environment. For Freud, abnormal behavior was the failure of internal adaptation. For Hartman pathology is the failure of both internal and external adaptations.

Erik Erikson retained many features of classical psychoanalysis, but extended it. Again, he employed the id, ego, and superego, but concentrated on the ego: ego identity, ego ideal, and ego quality. The motivational model of Erikson is strongly related to his psychosocial (as opposed to Freud's psychosexual) developmental stages. The first four stages of Erikson correspond to Freud's first four. The source of all motivation is the continuously changing ego that drives the individual to master the environment and move through the eight stages of development. The ego (person) develops healthily only if each stage-related crisis or task is successfully resolved. Therapy is more direct and problem oriented rather than employing free association.

It is important to point out that Hartman and Erikson reduced the emphasis upon the influence of internal processes on behavior even though they retained the structural elements of classical psychoanalytic theory. Thus, the motivational, developmental, abnormal and therapeutic elements changed, not the structural. The views on maturity and mental health in the newer systems should be discussed. Also to be addressed is whether the Hartman and Erikson systems lose the biases against understanding and changing aging-related behaviors noted in Freud's system. Are these systems explanatory, biased or simply partial explanations? Here it is appropriate to discuss (besides the age-related issues noted above):

a) whether the structural concepts (id, ego, superego) have been operationalized and validated.

b) which of the motivational elements of Freud, Hartman, Erikson have been research validated and which have greater real-world or "face validity."

c) which theory best lends itself to accumulation of direct evidence relative to support or nonsupport.

d) which of the theories thus far discussed is most helpful in predicting behavior, in general, in the elderly.

e) which theory is least age-biased or best in explaining how to correct abnormal behavior often seen in the elderly.

Key Concepts

Hartman

1. Ego psychology
2. Assumptions of ego psychology
3. New roles for the ego
4. Structural elements: id, ego, superego
5. New motivational elements
6. Differentiation of the ego (broader roles) rather than developmental stages
7. An expansion of pathology as a failure of both internal and external adaptations
8. What is mental health?
9. What promotes healthy old age?

Erikson

1. Emphasis on the ego: ego identity, ego ideal, ego quality
2. Strivings for competence/mastery of the environment

3. Eight psycho*social* stages
4. Ego differentiation drives the individual to master the environment and move through the psychosocial stages
5. Abnormal elements: ego develops in relation to stage related crises or tasks
6. What is maturity and mental health?
7. What promotes healthy old age?
8. What approaches might correct problems often noted in later life?

Film

Professor Erik Erikson

Suggested Readings

Gatchel and Mears, Chp. 4: Ego psychology and the neo-Freudians.

SESSION 4: DEVELOPMENTAL TASK THEORISTS (MARGARET BLENKNER AND ROBERT PECK) AND A MAJOR TRAIT THEORIST (GORDON ALLPORT)

Overview of Session Content

A. Blenkner and Peck

This session should begin with the concept of development as a biological notion, a process by which an organism changes through time in a species-specific manner. The process is *sequential*, *cumulative*, and *irreversible*, an interaction of genetics and the environment. The process is one of *becoming*.

There is too much stress placed on later life as a period of various pathologies, rather than a part of life that also provides opportunity for positive change or growth. Erikson offers the best starting point and carries us beyond Freud's stage of genital maturity. It should then be noted that Peck's view (supported by Blenkner) moves the point even further. He carries us beyond physiological powers by adequately describing what it means to be a human being. Peck places an emphasis on human uniqueness and the continued (normal and expected) development of mental and social powers. Peck posits that these qualities may develop better in later life.

Peck's arguments should be discussed in light of what our culture believes of the elderly, what the participants have noted in the elderly, and how they compare (agree-disagree) with the previously discussed theories. Peck states that only in the years beyond the mid-point is it that human beings have the necessary *experience* to develop fully what we call *wisdom*. This suggests a true developmental process in the second half of life. The instructor should also offer for discussion:

a) Peck's three reasons for looking at important aspects of aging with a developmental view.

b) Peck's developmental stages and tasks through old age.

c) The division of Erikson's final stage (of about 40 years) into additional stages: Middle Age (40s and 50s) and Old Age (60 and above).

d) The *Ultimate Goal*: the end point; not some physiological state, an end-of-life state of mind whose vision shapes and colors all the actions of the older person.

e) Abnormal elements: imperfect development in the *later* periods. *But*, there is possibility for positive change.

B. Major Trait Theorist: Gordon Allport

The discussion might begin with the arguments over the definition and function of traits as well as the agreements. Traits are posited to be relatively enduring and frequent, have cross-situational consistency, and certain ones have greater priority than others.

Allport considered traits the basic elements of personality, and offered definitions of traits that varied over time. Traits are structural elements for Allport, as well as motivational elements, initiating and guiding behavior. Differences in Freud and Allport include:

a) Allport believed that motivational systems of children and adults are different

b) biological development (says Allport) is important for children, but

c) adults are not captives of the past.

Thus, the adult, the older person, can be other than what his/her biology and childhood present. Adults can change.

Allport's four major requirements for a comprehensive theory of motivation are to be discussed, especially the concept of functional autonomy. His notion of development centers around need fulfillment which results in transformation from childhood to adulthood. Development of selfhood and the proprium (sense of self) emerges in seven developmental stages. Abnormal elements are related to the proprium. Without a mature proprium (a stage 7 developmental goal/task), an adult is not able to escape primitive needs of childhood. The motivational/systems of healthy and disturbed people are different. Allport lists characteristics by which a mature (normal) individual can be described. For Allport, pathology was the absence of normal characteristics. But, how do we undo pathology? A nonspecific, hard to operationalize answer includes: direct growth and development toward the seven criteria of maturity.

Class discussion might again center on how Allport's trait theory is different from psychoanalytic and ego psychology positions. Which is more positive? Which best explains pathology and pathology in later life? Which offers the best hope for change and the greatest clarity as to how to promote positive change? Which offers the greatest encouragement relative to problems often noted in the elderly?

Key Concepts

A. **Peck & Blenkner**

1. Development as a biological notion
2. Erikson's eighth psychosocial stage (Integrity vs. Despair)
3. Peck's developmental views and elaborations of Erikson's final stage: middle age tasks (crises), old age tasks
4. Peck's Ultimate Goal
5. Elaboration on why Peck offers a thesis of a truly developmental process in the second half of life.

B. **Allport**

1. Mental structures (Freud) vs. traits
2. Arguments and agreements over the definition and function of traits
3. Allport's trait theory: traits are structural and motivational elements in personality
4. Allport's definition of traits
5. Differences in adult and child motivational systems

6. Allport's four requirements for a comprehensive theory of motivation
7. Developmental elements including development of selfhood and the proprium (7 stages)
8. What is a mature, normal adult?
9. How is positive change in any age effected?

Film

Dr. Gordon Allport

Suggested Readings

Gatchel and Mears, Chp. 8: Major trait approaches.

Blenkner, "Developmental Considerations and the Older Client."

SESSION 5: PERSONALITY THEORIES AS EXPLANATIONS FOR BEHAVIOR: MAJOR TRAIT THEORIST, RAYMOND CATTELL

Overview of Session Content

The discussion might initially center on the similarities noted between Allport and Cattell's trait theories and then point out Cattell's differences. Both consider the trait to be the basic element of personality, with some traits being more basic. The self helps integrate component traits. Whereas Allport studied individuals intensely, Cattell is interested in finding general principles that apply to more than one person. His approach is through factor analysis. For Cattell, personality is that which permits a prediction of what a person will do in a given situation. Traits are mental structures that help us predict consistency in our behavior. Cattell offers a specification equation by which you can predict a response (behavior) by knowing what traits are weighted in specific situations. Problems in using this equation include: a) in some situations certain traits should have greater influence than others, and b) often we do not know trait weightings until *after* the behavior occurs.

Cattell speaks of *surface* and *source* traits. *Constitutional* and *learned* source traits are most useful in predicting behavior. Thus, some traits can be learned and unlearned. The overt manifestation of source traits (also referred to as *dynamic traits*) is referred to as an *attitude*. The *self-sentiment* organizes and coordinates the hierarchical relationships among traits and the resultant attitudes (the *dynamic lattice*). Relative to developmental elements, Cattell refers to six stages of personality development. Abnormal elements are defined in terms of the *specification equation*. *Conflict* is the ratio of the sum of negative elements to the sum of positive elements across the entire set of an individual's attitudes. Therapeutic elements are not a concern of Cattell.

Class discussions should center on the utility of this theory in understanding behavior in general, as well as high frequency problem behaviors noted in the elderly. Also, in this theory, what is a healthy and/or mature person? What are the origins of behavior and, then, the bases for change? Is the specification equation useful in altering problem behaviors? In explaining it? In predicting it? Do we all believe in traits? Why do others act in response to the traits we have noted, but we feel freer from ours?

Key Concepts

1. Cattell's trait theory
2. Nomothetic vs. Idiographic traits
3. Scientific approach to study of traits through factor analyses
4. Kinds of traits and how they are expressed

5. Specification Equation: how to predict/explain behavior
6. Motivational elements: dynamic traits, attitudes, dynamic lattice, self sentiment
7. Cattell's stages of personality development
8. Definition of conflict via the specification equation
9. Bases for inappropriate behavior in Cattell's system
10. Cattell's, or his system's, definition of mental health or maturity? What promotes healthy old age?
11. Is this theory age-biased? Useful relative to the elderly?

Film

Dr. Raymond Cattell

SESSION 6: TRAIT RESEARCH FINDINGS

This session serves as a bridge between the trait theorists and the learning theorists. The session begins with a historical examination of the question of whether behavior is determined by factors within the individual or the situation. The issue has been debated over a long period, beginning with Plato (who took a "situationist" position) and Aristotle (who took a "trait" position). The debate represents divergent world views and has had important social and political consequences. The trait-situation controversy is closely related to the nature-nurture controversy.

According to the extreme trait position, traits describe behavior which is consistent across situations and time. However, Mischel and others have observed that research indicates that individuals vary their behavior considerably across situations. An extreme situation position, on the other hand, would predict great consistency among individuals in any one situation. However, it is clear that individuals in the same situation may vary widely in their behavior. An interactionist position would expect that both traits and situations influence behavior. The interactionist position is the current dominant view.

Trait theory research supports an interactionist position: traits are useful predictors of behavior in fairly restricted circumstances. Most research has involved administering tests to measure traits, observing behavior, and then correlating the two. The consistency of traits varies as a function of a number of factors. First, consistency is a function of the research methodology; there is more consistency when behavior is sampled several times rather than only once. Second, some individuals are more consistent than others. Third, some behaviors are more consistent across situations. For example, an individual may be consistent across situations in terms of physical violence and inconsistent in terms of smiling. Finally, consistency is a function of the situation. Some situations, like church or the library, have powerful control over behavior, while others exercise little control. Traits obviously are better predictors in weak situations.

A primary goal of the session is to introduce the concept that behavior of the elderly has multiple causative factors. Mental health professionals, as well as the general public, tend to attribute behavior primarily to internal factors. The tendency is to overlook the contribution of environmental or situational factors to the behavior and problems of the elderly.

Key Concepts

1. Behavior is determined by both internal and external factors.
2. The results of scientific research is in part a function of the

methodology used.

3. Consistency of behavior is a function of a number of variables, including the methodology, person, behavior and situation.
4. Simplistic laws of human behavior would be convenient but are not realistic and may be dangerous. Most behavior is the result of complex interactions among multiple factors.
5. The exclusive focus upon the individual in mental health assessment and intervention is unrealistic.

Learning Activities/Labs

The exercise may be introduced by observing that people have varied through history in terms of their ideas about what determines behavior. Some have looked to external, or situational, factors while others have assumed that behavior is a result of internal factors within a person. Ask students to think about where the theorists studied so far would fall in this dichotomy. Ask about well known philosophers and political figures. Finally, ask them where they fall.

At some point, someone will point out that it is not easy to dichotomize theorists into one or another camp. Almost all will regard themselves as falling in between the extreme positions. The point can be made that, although the situation/trait controversy sometimes sounds like a dichotomy, in reality there is a continuum of thought between the two polor positions. This exercise provides an easy introduction to the interactionist position. It also provides a launching pad for a discussion of the folly of looking for simple "either/or" answers for human behavior and of the necessity for looking for multiple causation for most behavior.

Suggested Reading

Gatchel and Mears, Chp. 10: Trait theory research.

SESSION 7: LEARNING THEORY APPROACHES TO PERSONALITY DEVELOPMENT

Overview of Session Content

The discussion begins with the radical behaviorism of John Watson wherein behavior is believed to be learned as a result of one-way determinism (the environment alone affects learning and personality/ behavior). Watson's system has no inferred motives or internal processes for behavior, no mentalistic concepts. Behavior is a function of observable, measurable circumstances. At this point, demonstrations of classical conditioning noted in the text might be discussed.

Next the "theory" of E.L. Thorndike, or "psychological hedonism" is to be discussed, along with the law of effect. Thorndike postulated that individuals learn to do those things that produce pleasure and learn to avoid doing those things that cause pain. This eventually evolved into operant or instrumental conditioning (a behavior is strengthened or weakened based upon reinforcing consequence).

Operant conditioning was developed more fully by B.F. Skinner. For Skinner, operant conditioning involves the development of a new behavior that brings about positive consequences or removes negative ones. Behavior operates on the environment and has a goal. Also to be discussed are the types of reinforcement, the varied impact of schedules of reinforcement, and the importance of certain environmental cues (discriminative stimuli) that tell us when a behavior will be reinforced.

In Skinner's system the structural elements focus on observable behavior. Personality is behavior and can best be understood in terms of environmental conditions. In this system there is no need to hypothesize the presence of any internal structures of personality. The key motivational element is reinforcement. In terms of development, initially random behavior becomes, via shaping (contingent reinforcement), appropriate behavior. Later, self-reinforcement continues and polishes behavior. Thus, all behavior at all ages is socially controlled by contingent reinforcement by self and others. Learning principles are also used to explain pathology. All behavior is learned and can be unlearned via use of operant techniques. In this system, behavior and reinforcement are the focus of attention, rather than age or any posited internal constructs, for the explanation of behavior.

Last to be discussed is a body of cognitive social learning research primarily derived from the text. This collection of data emphasizes person-by-situation interactions, rather than person alone or environment alone. The discussion can begin with the influence of expectancy and locus of control in personality. A perception of little or no control over one's fate has a marked negative effect on behavior. How might this (and the concept of learned helplessness) relate to behavior often seen in the elderly in our culture? When an individual of any age learns that responding (or behaving) and reinforcement are independent - motivation for other coping behaviors is also undermined. Also, research on perceived control shows that individuals who believe they do have some influence over what happens to them handle stressful situations in a better fashion. These people are seen as better adjusted, less depressed, more trusting, etc. Thus there are behavioral correlates of locus of control (perceived control).

Self control is the internal regulation of behavior, or actual (as opposed to perceived) control. Those who can delay gratification are seen as future oriented, planful, responsible, trusting, less impulsive, and competent. Those wishing more immediate reinforcement are seen in more negative terms. One's own thoughts can make self-control easy or hard. We use the internalized values of the external world as self instructions. Also to be discussed are behavioral measures, facilitating and inhibiting conditions, situational specificity, and compliance relative to self control. Self control as a treatment strategy is discussed via research incorporating self-management techniques.

Behavior is not acquired solely through trial and error. People also develop many (and often complex) behaviors as a result of watching others and modeling them. It requires neither reinforcement nor practice, and it may or may not be demonstrated in performance (attitudes are often "silently" altered and expressed later, often indirectly). Observational learning shows the importance to personality theory of internalization and cognitive abilities. The discussion concludes with research findings elaborating on observational learning a) as a result of the characteristics of the model and the observer, b) television violence, and c) sex roles.

Key Concepts

A. Radical Behaviorism

1. Radical behaviorism - John Watson
2. Respondent or classical conditioning
3. One-way determinism
4. Psychological hedonism - E.L. Thorndike
5. Law of effect
6. Operant or instrumental conditioning - B.F. Skinner
7. Reinforcement vs. punishment
8. Reinforcement schedules
9. Discriminative stimulus

10. B.F. Skinner - structural, motivational, developmental, abnormal, and therapeutic elements

B. **Cognitive Social Learning Theory**

1. Mediating role of internal factors, especially cognitions
2. Stimuli and reinforcers can be internal as well as external
3. Social Learning Theory - Rotter
4. Specific and generalized expectancies
5. Cognitive/Behavioral approaches to psychopathology - Beck
6. Rational Emotive Therapy - Ellis
7. Social experiences shape cognitions and external behavior
8. Reinforcement value of identical stimuli vary across individuals
9. Reciprocal determinism
10. Role of age based stereotypes as cognitions

C. **Cognitive Social Learning Research**

1. Expectancy: Locus of Control
2. Perceived control and stress - research findings
3. Personal control in real-life situations
4. Behavioral correlates of perceived control
5. Actual (self) control - behavioral correlates
6. Measures of control
7. Facilitating and inhibiting conditions relative to self control
8. Self control as a treatment strategy
9. Observational learning and factors influencing it
10. Influence of observational learning on current and future behavior

D. **Overall**

1. Bases for normal behavior and pathology in each of the systems
2. Definitions of mental health or maturity
3. What promotes healthy old age?
4. Are the "theories" age-biased? Useful to understanding aging-related behavior in our culture?
5. How is positive change at any age effected?

Suggested Readings

Gatchel and Mears, Chp. 12: Learning theory orientations.

Gatchel and Mears, Chp. 14: Cognitive social learning research.

SESSION 8: PERSONALITY THEORIES AS EXPLANATIONS FOR BEHAVIOR: MAJOR PHENOMENOLOGICAL (CARL ROGERS) AND EXISTENTIAL (ERNEST BECKER) THEORIES

Overview of Session Content

Modern phenomenology does not deny that matter exists but focuses on consciousness and the individual's unique perception of objective reality. Reality is a private affair, not a social consensus. It varies with one's frame of reference. Phenomenological/humanistic theories focus more on growth than psychopathology. Basic features of phenomenology, as presented in the text, should be discussed.

Rogers' self-theory purports that behavior and personality are largely a function of the individual's own inner world of experience. He sees human behavior as basically rational and cooperative. Structural elements within this theory include the three internal dynamic agents: phenomenal field (the totality of consciousness available to an individual at one time), self or self-control (an internal locus of evaluation), and organism (the entirety of the person). Rogers believes the individual is a total system influenced by all of its components (phenomenal field, the self, physical body). Relative to motivation, Rogers hypothesizes internal, goal directed forces. The master motive is the actualizing tendency, the source of all behavior. Actualization only awaits proper conditions (what are they?) to be released and experienced. There is a drive to become, to become one's self. Allport offers no definite developmental stages regarding personality. Good parenting plus a good environment yields a healthy self structure (self actualized). Pathology occurs when an individual fails to achieve his/her potential. How does this apply to the elderly? Pathology is caused by barriers to potential (actualization). Rogers also talks of congruence and incongruence in terms of perceptions of whether a gulf exists between what the individual would like to be (ideal self) and what he/she really is. Incongruence becomes a stressor restricting growth, development and function. Lack of positive regard is another stressor. It results from a frustration of a need for positive regard. How does this part of Rogers' theory apply to the elderly in our society? Other stressors include anxiety, threat, and defensiveness. Rogers is an opponent of the medical model. He believes that one need only provide a proper relationship to foster positive growth tendencies. He developed client-centered therapy in which the role of the environment is important.

Key Concepts

A. **Carl Rogers' Self Theory**

1. Idealism and modern phenomenology
2. What is real? What is reality?

3. Emphasis is placed on growth rather than pathology
4. Basic features of phenomenology
5. Rogers' Self-Theory: structural, motivational, developmental, abnormal, and therapeutic elements
6. Three internal dynamic agents: phenomenal field, self or self-concept, organism
7. Master motive: internal, goal-directed forces seeking actualization of one's potential
8. Importance of the environment
9. Barriers to actualization: incongruence; lack of positive regard; anxiety, threat, and defensiveness
10. Client-centered therapy

B. **Existential Theory**

1. Common threads among existentialists:
   a. responsibility for self
   b. being; constant state of evolution
   c. non-being (death, meaninglessness, isolation, loss)
   d. existential anxiety vs. neurotic anxiety
   e. will (to power, to meaning, etc.)
   f. situational ethics.
2. Logotherapy - Frankl
3. Becker - synthesis of existential and psychoanalytic thought
4. Psychopathology as behavior resulting from attempts to avoid experiencing existential anxiety
5. Death awareness as a developmental process
6. Authenticity as a result of accepting human frailty,

tenuousness of existence.

7. Confrontation with nonbeing less avoidable with old age, results may be extreme attempts to deny or intense anxiety

C. **Overall Key Concepts**

1. What are the bases for normal behavior and pathology in each of the systems discussed in this session?
2. Definitions of mental health or maturity? Is it possible?
3. What, according to this session's theories, promotes healthy old age?
4. Are the theories age-biased? Useful to understanding aging-related behavior in our culture?
5. How is positive change, using this session's theories, at any age effected?

Learning Activities/Labs

Part of the lecture deals with reality as a private affair, dependent upon one's frame of reference. It is suggested that people construct their own special perception of reality, particularly the more ambiguous and difficult it is to interpret a situation. This is demonstrated via the use of an "ink-blot" design created by the instructor. The design is held up, and rotated slowly, so that each participant gets a good view of the same, concrete stimulus. Each student is asked to "tell me what you see" by writing it on paper he/she would keep. They do not have to share their answers. Subsequently, volunteers are asked to say what they see. Each response is written on the chalk-board. The major point becomes clear as some answers overlap but many present unique perceptions of the objective world. The students are reminded that they all viewed the same physical stimulus but generate overlapping and divergent interpretations. How could reality be so many different things? What is reality? Is our behavior a result of "reality/truth" or our interpretations and perceptions. This exercise leads into the basic features of phenomenology and Rogers' concept of phenomenal field (the subjective perception of reality that determines behavior).

Suggested Readings

Gatchel and Mears, Chp. 17: Major phenomenological - humanistic approaches.

SESSION 9: FORMAL MODELS FOR EXPLAINING BEHAVIOR: MEDICAL, SOCIAL, BEHAVIORAL, AND INTERACTION MODELS

Overview of Session Content

What is aging? Each of the models under discussion might answer the questions differently and in a narrow or incomplete fashion. Each model "creeps" into decision making, particularly in response to aging issues and all are products of culture.

The instructor might have a brief group discussion on the definition of aging and the bases for abnormal behavior in old age. This discussion can be used to highlight the medical, behavioral, social, or interactive model preferred by class members. Then ask what they believe to be the bases for normal and abnormal behaviors in younger adults. Notice whether they shift from one explanatory model to another as the age variable changes. This is often surprising and revealing to the class. Also, try to establish the bases for the models and note how certain models are a function, and supporter, of specific theories of personality. For example, which theories of personality are congruent with the medical model. Note how the behavioral model of aging and abnormal behavior conflicts with certain theories studied by the class. One cannot, for example, explain behavior via the medical model and also wholly espouse/support Allport's Self Theory of development and abnormal behavior without there being, at the least, conceptual incongruence.

The above exercises and discussion relating theories to models, etc., are interwoven in discussions of each of the relevant models. Important: All models are valid and indispensable conceptualizations for explaining psychopathology in old age but are often insufficient when used as the sole explanation. Models have replaced theories of personality as explanatory concepts and systems.

The way in which the aging process is conceptualized will to a large extent dictate the use of a particular intervention approach. It also affects the quality and extent of assessment. The social model attributes changes in behavior, or differences in behavior between the elderly and younger adults, to different roles permitted each of these groups by their culture/society. We tend to expect less responsibility and decreased functional ability from our society's older members in many areas but particularly in self-care behavior, task behavior, and relationship behavior. The medical model considers deviation from normal functioning as due to illness or disease, most notably, improper physiological functioning that purportedly occurs as a natural (and expected) consequence of aging. The behavioral model sees behavior as a product of learning and learning is a result of environmental events occurring immediately before a behavior (antecedent events) and immediately after a behavior (consequence of the behavior, or reinforcer). As one ages, both the antecedent and consequent events associated with behavior change. Thus, behaviors change. Some appropriate behaviors are gradually lost due to changes in antecedent and reinforcing conditions and other (perhaps inappropriate) behaviors appear in response to newer environmental cues (antecedents) and effects (consequences).

The three models have been viewed as in conflict. The instructor can help the group move away from that longstanding battle to a more useful position. It is obvious that changes in all three (the *integrative/interactive model*) classes of variables occur throughout the life-span. All three, therefore, may be considered as causes of changes associated with aging. Previously, too much emphasis was placed on the medical model in trying to understand changes in behavior in the elderly. However, any of the noted models can be overemphasized. *It is necessary* to have knowledge of the deficits and excesses within all three classes of variables in order to fully understand the behavior of any older person, and his/her level of *environmental competence*. Without such an integrated/interactive approach, restoration of adaptive behavior is not likely to be complete.

Key Concepts

1. What is aging?
2. What are the bases for abnormal behavior in old age?
3. What are the bases for abnormal behavior in young adults?
4. What theories of personality are congruent with what models for explaining aging-related behavior?
5. Have models replaced theories?
6. How do models influence our decisions relative to older people?
7. The social model
8. The medical model

9. The behavioral model
10. The integrated (interactive) model
11. Environmental competence: recognizing the importance of person-situation interaction and person-situation congruence
12. The value of an age-free model

Suggested Readings

Baltes & Barton, "New approaches toward aging: A case for the operant model."

Birren & Renner, "Concepts and criteria of mental health and aging."

Dupree, O'Sullivan, & Patterson, "Problems relating to aging: Rationale for a behavioral approach."

Miller, "Toward a classification of aging behaviors."

SESSION 10: CULTURALLY BASED "EXPLANATORY MODELS": LAY MODELS, PROFESSIONAL BIAS (AGEISM), SOCIAL CLASS AND MENTAL ILLNESS

Overview of Session Content

The focus of the session is upon pervasive lay "Explanatory Models" of mental illness and of aging. These models affect the attitudes of most members of the society, including mental health professionals. Special attention is given to the impact which common stereotypes and prejudices have upon the treatment of the mentally ill elderly.

The session is organized around a class discussion of the assigned readings, which emphasize different aspects of the topic. The article by Butler provides a launching pad for a discussion of the prevalence of "age-ism" in our society and a comparison of ageism with other forms of prejudice, like racism.

Both the mentally ill and the aged suffer from being "labeled." The Neff and Husaini article provides empirical evidence of the negative impact of labeling upon public attitudes toward mental illness. Their findings support that a propensity to label deviant individuals is associated with less tolerance for the deviance.

The Rodin and Langer article focuses upon age labels. They present data from a number of studies which support the hypothesis that labeling and stereotyping the elderly result in stigmatization, which contributes to low self-esteem and diminished feelings of control. The negative aging stereotypes are so prevalent in our society that they alter the way younger adults typically treat older adults. Older people are commonly patronized, avoided, or worse.

The elderly themselves have misconceptions about the problems experienced by most of the aged. O'Gorman analyzed data from a national survey of elderly people and found that, in general, older adults exaggerate the negative images of older people. They tend to overestimate the prevalence of serious problems among older adults. If they do not have a very serious problem, they mistakenly perceive themselves as unlike the majority.

A common myth in our society is that most elderly become "senile." If Grandma forgets her keys, she's senile; if her middle-aged son forgets his, he's just busy. Studies abound which suggest that various mental health professionals tend to overdiagnose dementia among older adults, even when the symptoms might be attributed to other causes. The result is tragic in that the misdiagnosed individuals are believed to be untreatable and therefore they are not likely to receive adequate treatment. The reading by Ciliberto, Levin and Arluke describes one such study which utilized nurses as subjects. Other studies examining psychologists, psychiatrists, etc. could easily be substituted in the readings.

Mental health services are not as likely to be provided for older adults as they are for younger adults. Mental health and aging professionals frequently mention a number of barriers which prevent the development of adequate mental health programs for the elderly, often blaming the elderly themselves. Belief that a barrier exists is a great barrier itself. Pratt and Kethley examined the barriers as anticipated by professionals and those actually encountered. There were some major differences between the anticipated and actual barriers. Some anticipated barriers which were much less a hindrance than expected were the presence of more urgent problems and the negative attitudes of the elderly. In contrast, organizational bureaucracy (not anticipated by any of the participants) was the greatest actual barrier.

Key Concepts

1. Ageism is pervasive, found among the general public, mental health professionals, and the elderly themselves.
2. The consequences of the labels applied to the elderly and the mentally ill are debilitating.
3. A great deal of the "knowledge" about aging and mental illness is really misinformation.
4. The negative stereotypes about aging and mental illness have definite, strong detrimental impact, especially upon the mentally ill elderly.
5. The elderly mentally ill receive inadequate services: drug therapy rather than other forms.

6. "Warehousing."

Suggested Readings

Butler, "Age-ism: Another form of bigotry."

Ciliberto, Levin, and Arluke, "Nurses' diagnostic stereotyping of the elderly."

Neff & Husaini, "Lay images of mental illness: Social knowledge and tolerance of the mentally ill."

O'Gorman, "False consciousness of kind."

Pratt & Kethley, "Anticipated and actual barriers to developing community mental health programs for the elderly."

Rodin & Langer, "Aging labels: The decline of control and the fall of self-esteem."

Film

Aging

SESSION 11: MID-TERM EXAM

SESSION 12 & (PART OF) 13: CLASSIFICATION AND ASSESSMENT OF OLDER ADULT BEHAVIOR

Overview of Session Content

When an older adult comes to the attention of the mental health system, there may be many factors contributing to the presenting problem besides psychopathology in the individual. Yet there is a strong tendency to overattribute the causation of problems to pathology within the individual and to design interventions targeting the individual. The session is designed to examine some of the factors which contribute to problems frequently seen in mental health settings. A systems approach is taken in which assessment includes an examination of environmental contributions to the problem, available resources, the functional utility of problem behavior and alternative targets for intervention.

Many of the individuals who come into the mental health system are not "mentally ill"; rather, they are experiencing "problems in living" which they may need assistance in resolving. The DSM III includes a list of some of the conditions not attributable to a mental health disorder which may become the focus of mental health treatment. Many of these conditions for the elderly involve normal responses to stressful events.

Stress is an important concept for mental health professionals working with the elderly. Stress is believed to be a causative factor in much physical and mental illness. One cannot assume that one understands the impact of stressful events for another person. Individuals vary considerably in their response to the same stimuli. The stress which an individual experiences as a result of an event is a function of many variables, including coping style, ethnic background, resources, and the presence of other stressors.

Coping styles differ widely in their effectiveness in varying situations. Often, previously effective coping strategies are inadequate in meeting the demands of old age. Psychopathology can result when the coping resources of the individual are exceeded. Teaching new coping techniques and developing new resources can be effective interventions.

It is helpful to examine the individual's interactions with his/her social and physical environment. There is no "best" environment for the elderly; the tremendous diversity among older adults means that an individual by environment fit approach must be taken. A change of environment is often a "magical" intervention in changing problem behavior.

The functional utility of problem behavior requires careful assessment. That which is learned may be unlearned, but not unless the contingencies are understood and the intervention is well planned. Behavior occurs within an ecological system; unless a systems approach is taken, unintended consequences are likely to occur.

Finally, assessment of behavior needs to consider developmental changes. The Kuhlen article suggests that motivational patterns change during the adult life span. The importance of anxiety and threat increase with age and are associated with many behavioral changes. The mental health professional working with the elderly needs to be familiar with these normal developmental patterns.

Key Concepts

1. "Problems in living" vs. psychopathology
2. Stress and mental and physical illness
3. Normal responses to stressful events
4. Coping styles
5. The relationship between coping skills and mental health
6. Person by environment fit
7. Behavioral analysis and modification
8. Behavioral ecology
9. Developmental changes in motivation during adulthood
10. Systems approach

Suggested Readings

Kahana & Kahana, "Stress reactions."

Kuhlen, "Developmental changes in motivation during the adult years."

Linn, Hunter, & Perry, "Differences by sex and ethnicity in the psychosocial adjustment of the elderly."

Rebok & Hoyer, "The functional context of elderly behavior."

West & Simons, "Sex differences in stress, coping resources, and illness among the elderly."

SESSION 13 (PART OF), SESSION 14, SESSION 15 (PART OF):

DEVELOPMENTAL TASKS AND PROBLEMS THAT OFTEN BRING OLDER ADULTS TO THE ATTENTION OF MENTAL HEALTH PROVIDERS

Overview of Session Content

These sessions focus on reactions to aging-related changes that do not result in psychopathology as typically defined by the DSM-III, but result in problem behaviors often noted in the literature and needing attention. Often the family (present, absent, real or imagined) is the cauldron in which many of these problems are created and/or maintained. Thus, the first issue for these sessions deals with family influence on problem behaviors. The main supportive article is, "The Changing Family Context of Mental Health and Aging" (Bengston and Treas, 1980). An important point is that we have elaborated upon and built up an overly positive (idealized) version of three-generational family life; and then both children of elderly and the elderly seek and expect the idealized. These myths or expectancies cause problems for both generations. The discussion might then lead into facts that more accurately portray family life of the past and how it is currently. How individuals and families negotiate change (an inevitability associated with aging) is also to be discussed, along with expectable transitions in old age. Other issues to be discussed include:

a) four crises to well-being

b) families, socialization, and the "normal career of aging"

c) implications for mental health policy and practice,

d) factors that mediate the impact of intergenerational relations on the aged, and

e) ways in which family relations contribute to the mental health of older family members

The theme of this discussion is that we overlook the family's (present or absent) influence on mental health, as well as perhaps attribute too much to culture or society.

The elderly are often criticized for not being active and involved and some have even developed expectations of withdrawal or disengagement. Also, our culture tends to expect the elderly to have diminishing areas of responsibility. Add loss of predictability to the equation and we should expect negative (perhaps inappropriate) reactions. The effects of control and predictability on the physical and psychological well-being of younger adults have been well documented. A more recent study of institutionalized aged demonstrates similar effects. The researchers hypothesized that some of the characteristics frequently observed among the elderly, such as accelerated physical decline, are at least in part attributable to loss of control. Using proper controls, it was found that predictable and controllable positive events have a powerful positive impact upon the well-being of the institutionalized aged. Often minor family and/or institutional changes that increase feelings of control and predictability of future events favorably impact the mental health status of the aged.

Bereavement and the related phenomena of grief, loss and mourning become increasingly frequent experiences as we age. Using the assigned review article as a basis, the discussion centers on understanding the nature and effects of bereavement for adults, and suggested approaches to its management or treatment.

The relationships between the elderly and their caregivers in *shared* households are complex and not easily predicted as to positive or negative impact on either participant. An assigned article details the result of an *elder-caregiver relationship study*. Discussion should involve the noted results: a) the impact of demands on the caregiver or the dyadic relationship are mediated by the impact of elder's presence on household functioning, b) the elder's contribution to household tasks, and c) the availability of alternative caregivers.

Aging and *sexual dysfunction* are not directly related. Sexual dysfunction in the elderly is usually a problem for males and related to erectile dysfunction caused by chronic physical conditions, various chemicals (medications, alcohol abuse), culturally-based "self-fulfilling prophecies", and "widower's syndrome" which is related to performance anxiety. Many sexual problems of the elderly (usually males) are the result of *inadequate knowledge* regarding normal aging related changes (not the same as dysfunction) and interpreting those changes as foretelling a sexless life. Cultural "fact" leads to negative prophecy. Often the problem can be undone via information and explanation of the normal changes in the sexual response cycle.

Physiological changes have been noted to be associated with psychopathology in the elderly. *Hearing and visual deficits* are common in the elderly, with greater attention being paid to remediation of visual changes. The evidence clearly points out that hearing loss in later life is not merely a cause of social isolation, but also of psychological distress, which is most commonly expressed as anxiety. Also, one major study of 93 individuals with later-life onset psychotic behavior found that between 30 and 40 percent also experienced major hearing difficulties. Thus, sensory impairments are contributory, if not causative, with hearing loss having the highest relationship to paranoid (and associated delusional) behavior. Vision problems are also related. It should be discussed with the class participants that behavioral remediation should first begin with physical/sensory evaluation and remediation. Subsequent needs for psychotherapy or counseling may be minimal.

At least part of Session 15 is for review and a final overview of the epidemiology of mental illness in later-life. This offers closure for this course and sets the stage for Psychopathology and Aging II. The assigned article, "The Epidemiology of Mental Illness in Late Life" is the basis for the discussion. The review discusses problems in obtaining accurate incidence and prevalence rates due to case identification problems; the distribution of mental illness rates by location of the older person (hospital, community, etc.); the variability of psychiatric disorders by diagnostic category by location; historical trends in mental illness of older adults; etiology of mental illness in older populations; and the need for a comprehensive, multidimensional model of causation.

Key Concepts

1. The psychological consequences related to common developmental tasks and problems of the elderly
2. Myths associated with three-generational families and their impact on the mental health of the elderly and their children

3. The "normal career of aging" and four crises to well-being
4. Caregiver burden? Variables associated with elder-caregiver relationships in shared households
5. Bereavement and related phenomena of grief, loss, and mourning
6. The effects of control and predictability on the physical and psychological well-being of older adults
7. The normal aging sexual response cycle and variables of potential impact
8. Sensory deficits related to certain forms of psychopathology in the elderly
9. Epidemiology of mental illness in later life including models of causation

Suggested Readings

American Psychiatric Association, Chp. 2: Use of this manual.

Blazer, Chp. 10: The epidemiology of mental illness in late life.

Feinson, "Aging and mental health."

Meer, "Loneliness: Whether being lonely is a sometime thing or a sad way of life, understanding its causes can help."

Schulz, "Effects of control and predictability on the physical and psychological well-being of the institutionalized aged."

Stoller, "Elder-caregiver relationships in shared households."

Wan, "Health consequences of major role losses in later life."

Warren, "Bereavement: A brief review."

Film

When Parents Grow Old

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Chapter 5

PSYCHOPATHOLOGY AND AGING II

Victoria K. Dunn, M.A.
Center for Applied Gerontology
and
Department of Clinical/Community Psychology

Larry W. Dupree, Ph.D.
Chair, Department of Aging and Mental Health
Florida Mental Health Institute

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GEY 6615

PSYCHOPATHOLOGY & AGING II

Course Objectives

After completion of this course, students should be able:

1. To understand the basic concepts and assumptions of the American Psychiatric Association's DSM III and their application to mental disorders common among older adults.
2. To better understand psychopathology in late-life via a basic framework of: a) features or symptoms most commonly observed among older adults, b) clinical types/categories, c) causal theories specific to the older population, d) prevalence reports, and e) prognosis and implications for change later in life.
3. To know how to make a differential diagnosis specific to issues presented by older adults, including reliable use of decision trees.

Course Description

I. Introduction to the mental disorders common among older adults
  a. Basic concepts and assumptions of the DSM-III
  b. Basic framework for discussing subsequent disorders
  c. Legal and ethical issues

II. Common organic disorders in older adults
  a. Dementia
  b. Delirium
  c. Substance-induced disorders common among older adults

III. Functional disorders

- a. Anxiety disorders
- b. Affective disorders
- c. Schizophrenic disorders
- d. Paranoid disorders
- e. Substance use disorders
- f. Adjustment disorders commonly associated with later life.
- g. Personality disorders
- h. Somatoform and dissociative disorders
- i. Psychophysiological disorders
- j. Psychosexual disorders

IV. Differential diagnosis

- a. Use of DSM-III decision trees, use of additional decision trees
- b. Pseudodementia and other differential diagnosis issues of relevance to older adults -- review and summary

Course Requirements

Grades are based primarily upon the midterm and final examinations. The exams are take-home, open-book exams which students are encouraged to discuss among themselves. The exams consist primarily of case studies which students are responsible for discussing and assigning DSM III diagnoses. Exams cover all material presented in class and assigned readings.

Suggested Texts

1) Whanger & Myers, Mental Health Assessment and Therapeutic Interventions with Older Adults.

2) American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (DSM-III)

SESSIONS

SESSION 1: INTRODUCTION

Overview of Session Content

The initial session is largely organizational with discussion of the syllabus. Backgrounds of instructors are described. A basic framework for studying and comparing mental disorders common to the elderly is presented and key concepts are discussed. Student backgrounds are explored and students are encouraged to contribute to class discussions from their own areas of expertise.

Key Concepts

A basic framework for discussing subsequent disorders includes the following elements:

1. Features and symptoms most commonly observed among elderly
2. Clinical types commonly observed among older adults
3. Etiology - causal theories and relevance to the elderly
4. Prevalence and incidence in the general population and in the elderly
5. Prognosis and factors which impact prognosis for older adults
6. Brief treatment discussion per major clinical entity

Although the diagnostic categories will be discussed one at a time, it is important to remember that the observable manifestations of many categories overlap considerably. For example, depression, dementia, and delirium may look similar among older adults. Therefore, differential diagnosis is a constant concern and mental health workers need to be alert to the concurrent existence of multiple disorders.

Learning Activities/Labs

A class exercise is conducted to point out the behavioral similarities of depression, dementia, alcohol abuse, and medication abuse/misuse, as well as the need for differentiating among them for intervention purposes. Inform the students the papers are not to be collected; names are not necessary. First, students are asked to list 3-5 signs (characteristics, symptoms, behaviors) associated with dementia. Next, repeat for depression, alcohol abuse, and medication misuse/abuse. Using a chalkboard, ask for volunteers to provide symptoms they associate with the disorders being discussed, taking time to elicit as many responses as possible from each student. Ask for information in reverse order. That is, first ask for symptoms related to medication misuse/abuse, then alcohol abuse, depression, and dementia. At some point the class usually notices the cross category redundancy in symptoms and often by the time the category of dementia is reached, someone responds "all of the above" or "most of what we have discussed." This exercise points out the similarities among problem behaviors often noted in the elderly, the need for clarity in differentiating disorders for intervention purposes, how the DSM III might assist, how intervention might influence our decision (since dementia is a diagnosis by exclusion), and how social and medical evaluation play significant roles in a complete evaluation of psychopathology, particularly in the elderly.

Suggested Readings

Whanger & Myers, Chp. 1: Understanding the aging process and the mental health needs of older adults.

SESSION 2: DSM-III, LEGAL & ETHICAL ISSUES

Overview of Session Content

The purpose of the discussion of legal issues is to illuminate the overlap between psychopathology and the law. Students working with older adults need to understand that although similar terms (such as "competence") are used by mental health and legal professionals, the meanings and implications are quite different. The state laws defining and delineating legal assessment of "insanity" and "competence" are discussed. The implications for the elderly are explored, with emphasis upon the personal impact of use and abuse of the legal system.

This session provides a general overview of the development, objectives and evaluation of the DSM-III, noting major significant differences and achievements of the DSM-III over its predecessor. Also noted is its pervasive influence upon the diagnostic process in most mental health settings. More specifically, the structure of the system (the five axes) are discussed, along with content appropriate to each of the axes and how that content is derived. Lastly, the influence of the DSM-III diagnostic criteria and axes upon sufficient diagnostic interviewing is discussed.

Key Concepts

A. Basic concepts and assumptions of the DSM-III

   1. Development of, differences in, DSM-III
   2. Multiaxial classification
   3. Allocation of major classifications by Axis (I-IV)
   4. The diagnostic process: Uses of Axes I-V
   5. Multiple diagnoses
   6. Implications for diagnostic interviewing

B. Legal & ethical issues

The legal definitions of competence differ between competence to stand trial and competence to manage one's affairs.

Procedures for determining competence vary considerably across legal jurisdictions and even within a jurisdiction. The adequacy of the investigation and of the investigative team also varies.

The problem of falsely declaring elders to be incompetent has so sensitized the public and potential guardians that there is often a tendency to avoid obtaining guardianship for people who urgently need it.

Learning Activities/Labs

Class discussion

Suggested Readings

American Psychiatric Association, Chp. 2.

Whanger & Myers, Chp. 2:

Legal issues

Florida statutes

SESSION 3: ORGANIC MENTAL DISORDERS

Overview of Session Content

The primary focus of the session is to examine the Organic Mental Disorders as detailed in the DSM-III, and to establish prevalence rates for various age cohorts age 65 and above. Also discussed are suppositions relative to etiology, possible intervention, and criteria for additional evaluation. Students are to be made aware that: "organic brain syndrome" is used to refer to a constellation of psychological or behavioral signs and symptoms without reference to etiology (e.g., Delirium, Dementia); "organic mental disorders" designates a particular organic brain syndrome in which the etiology is known or presumed (e.g., Alcohol Withdrawal Delirium, Multi-infarct Dementia). (DSM-III, p. 101).

Key Concepts

Common organic disorders in the elderly:

A. Dementia

   1. Primary Degenerative Dementia (Alzheimer's Disease)
   2. Multi-infarct Dementia

B. Delirium

   1. Multiplicity of causes: infections, medications, brain lesions, metabolic and nutritional disorders, etc.
   2. Increased susceptibility of the elderly

C. Substance-induced organic mental disorders

   Substance types vary and induce a variety of behaviors (often believed to be age-related)

Prevalence and incidence rates for the organic mental disorders/syndromes, particularly for Dementia, are few and unreliable. Purportedly, there are between 1.5 to 2.5 million people diagnosed as having some form of dementia in the United States. There are reported prevalence rates of 4-6 percent after age 65, to 20 percent after age 85; with reported incidence rates of from 110 to 380 cases per 100,000 individuals over ages 29 and 60, respectively. In general, the reported prevalence rates (which are often the products of seriously flawed research endeavors) show a 10 to 20 fold increase between the ages 60 and 80, exceeding 20 percent by age 85. Of the dementias, more people are diagnosed as having Primary Degenerative Dementia (Alzheimer's type) than Multi-infarct Dementia. Most importantly, it should be emphasized that dementia is not a normal part of aging.

The prevalence of substance-induced mental disorders in the elderly is even harder to ascertain in view of its "hidden" nature and often being in response to licit medications prescribed for other conditions. This area is one of growing concern and is compounded when additional drugs are given to counter the "dementia" or "delirium."

No known physiological condition is associated with depressive pseudodementia. It is a major depressive disorder generating loss of memory, difficulty in concentrating, and a general loss in intellectual performance. It is believed that many hospitalized elderly (including those in long term care facilities) are there as a result of a reversible disorder, depression, rather than true dementia.

The current most actively researched organic mental disorder is Alzheimer's Disease (Primary Degenerative Dementia), especially its etiology. The research efforts reviewed include biochemical (particularly, acetylcholine) studies, as well as trace metal, infectious agents, immunnological, genetic, and psychosocial studies.

Medications currently hold little promise for Alzheimer's disease victims, but evaluation and subsequent medication for other concomitant disorders is often warranted. The social support network is often crucial in determining long-term care placement versus community living. Also, a structured environment, with caregivers using behavioral approaches for the maintenance of independent living skills, increases the likelihood of community living. Caregivers as well as patients need understanding and support.

The diagnosis of Alzheimer's disease is by exclusion. Once one knows what the diagnosis is not, one is left with one probable explanation (assuming DSM-III criteria are met) - Alzheimer's disease. However, the most common cause of forgetfulness, confusion, and disorientation in the aged is drug intoxication. The elderly are a multimedicated group.

Suggested Readings

American Psychiatric Association, pp. 101-128.

Whanger & Myers, Chp. 3: Organic mental disorders

SESSION 4: AFFECTIVE DISORDERS

Overview of Session Content

The session examines the Affective Disorders of the DSM III, as they apply to the elderly, using the framework established in the initial session. Particular emphasis is placed upon depression which is the most common functional disorder among older adults, the "common cold" of mental illness among the elderly. A major thrust of the session is to encourage students to look for and treat depression, even in the presence of dementia.

Key Concepts

The DSM-III includes three groups of Affective Disorders:

A. Major Affective Disorders
  1) Major Depression
  2) Bipolar disorder (Manic-depressive)
B. Other Specific Affective Disorders
  1) Cyclothymic disorder
  2) Dysthymic disorder
C. Atypical Affective Disorders

Prevalence and incidence statistics lack reliability due to problems in assessment and the failure of many to obtain treatment who warrant intervention. However, some estimates are:

1) The lifetime incidence for adults in general is 15% for depression and .4 to 1.2% for bipolar disorder (DSM-III).

2) Estimates of the prevalence for the elderly of depression range from 25% to 65%, with 10-15% who warrant interventions.

3) Nearly half of admissions of older adults to psychiatric hospitals are for depression.

Numerous approaches to establishing sub-classes of depression have been attempted. Although the types are widely used, the typology systems have not yet proven to be very useful or accurate. Some dichotomies which have been used are: psychotic and neurotic, endogenous and exogenous, and psychomotor agitation and retardation types.

Several major issues are of importance in considering geriatric depression. Some of these issues are: masked depression, pseudodementia, and the relationship between complaints of physical illness and depression. The problem of suicide, especially among elderly men, requires special attention.

Theories of the etiology of depression are numerous and not necessarily mutually exclusive. The biochemical theories have enjoyed recent popularity and are supported by several lines of research. The psychodynamically oriented theorists focus upon losses and anger turned inward. Cognitive theorists such as Ellis and Beck link maladaptive thought patterns to depression. The interpersonal relationships of people who tend to become depressed have received attention. Learned helplessness and a lack of positive behavior-contingent reinforcement have also been theorized to underlie depression. The stressors have frequently been mentioned as precipitating factors. The diathesis-stress model hypothesizes that depression requires both a predisposition to become depressed and precipitating events.

Assessment of depression among the elderly is made primarily upon the basis of an interview and history. Screening tests are available. A physical examination is needed to rule out an organic basis for the symptomatology.

A number of treatment approaches are available. Structure and pleasant activity (especially social activity) may be helpful for an older depressed person. Lithium is the treatment of choice for bipolar disorder. Other somatic treatments include tricyclic antidepressants and ECT. However, drug treatments present hazards which require careful monitoring. Psychotherapy tends to be underused with the elderly but can be helpful.

Suggested Readings

American Psychiatric Association, pp. 205-224.

Whanger & Myers, Chp. 4: Affective disorders.

SESSION 5: PARANOID & SCHIZOPHRENIC DISORDERS (ADDENDUM)

Overview of Session Content

All of the disorders discussed in this session involve (at some point in the illness) one or more of the following: the prominent presence of hallucinations, delusions, severely disrupted behaviors, or markedly disrupted thinking. Thus, the primary focus of the class time is to examine psychotic disorders outlined by the DSM-III, also pointing out the changes in manifestations of psychotic behaviors as a function of early-life versus later-life onset.

Key Concepts

The DSM-III includes five types of schizophrenia:

1. Disorganized Type
2. Catatonic Type
3. Paranoid Type
4. Undifferentiated Type
5. Residual Type

Note: the onset of a schizophrenic-like condition after age 45 cannot, via the DSM-III, be formally diagnosed as schizophrenia, but is to be diagnosed as an Atypical Psychosis. Thus, the Schizophrenic Disorder criteria are not applicable to later-life onset conditions, even when reflecting most of the behaviors noted in the schizophrenia criteria.

Four Paranoid Disorders are noted in the DSM-III:

1. Paranoia
2. Acute Paranoid Disorder
3. Shared Paranoid Disorder
4. Atypical Paranoid Disorder

Given that many schizophrenics beyond age 65 are not in hospitals and given that their symptoms are controlled somewhat by medications, reliable incidence/prevalence estimates of later-life onset schizophrenia are difficult to obtain. It has, however, been estimated that 4 percent of all schizophrenic illness in males occurs after age 65, with 14 percent of all schizophrenic illness in females occurring after age 65.

The great majority of elderly schizophrenic clients/patients develop the disorder much earlier in life. When it does develop in old age it is almost always of the paranoid type. Late-onset schizophrenia (often referred to as Paraphrenia) differs from early-onset cases:

a. Depressive affect is common in early-onset, but not in later-onset schizophrenia.

b. Elderly patients are more likely to be upset by their abnormal thoughts and perceptions.

c. Verbal incoherence, thought blocking or gross speech disorders are rarely seen in later-life onset.

d. Odd movements and behaviors are not common.

e. More often (for later-onset schizophrenia) the essential feature is a delusional state (often paranoid) arising in clear consciousness and an intact personality.

In summary, the range of expression of the schizophrenic behavior narrows, is usually paranoid in type and centers around a coordinated set of delusions. Aging also has a positive impact on early-onset schizophrenic disorders. The hallucinations are often less frequent and upsetting, there is less psychomotor activity, there are alterations in the delusions (or they disappear completely), and there may be "burnout" of schizophrenic symptoms.

Studies indicate that 1-2 percent of a group of community based elderly were considered to have major paranoid *disorders*; 11% reportedly experienced mild paranoid *symptoms*. Forty percent of a group of hospitalized elderly manifested paranoid symptoms (not of a danger to self or others). These symptoms were of fairly recent origin (later-life onset). Five to ten percent of a group of elderly admitted to mental hospitals were admitted for later-life onset paranoid disorders/conditions. True incidence/prevalence rates are difficult to obtain.

The frequency of paranoid symptoms reportedly tends to increase with age. This may be a realistic response to: (1) the way our culture thinks of, and treats the elderly; (2) internal and external losses (including sensory); and (3) both a perceived and actual increase in vulnerability to the effects of change. Often delusions become more systematized and integrated, approaching what might be called paranoia.

Research on the etiology of schizophrenia has included social class and status, the role of the family, genetic predispositions and biochemical factors. Speculations on the etiology of Paranoid Disorders also includes the role of the family, certain life-long personality traits and disorders, environmental/social factors, physical problems (e.g., sensory impairments; toxic agents; metabolic, nutritional and infectious disorders; neurologic diseases) and genetic factors. Most of the research data offer conclusions consistent with a diathesis-stress theory for schizophrenic disorders, and many theorists adhere to a similar theory for paranoid disorders. Problem: current theories of etiology were based on studies of early-onset disorders and may not be the etiologic bases for later-life onset schizophrenic or paranoid conditions.

Treatment approaches include drug therapy, traditional (often psychodynamic) psychotherapy, psychosocial skill building, behavior therapy, family therapy and, when necessary, hospitalization in the acute phase. Treatment should also incorporate a complete physical evaluation. In a major study of 93 elderly individuals diagnosed as having a late-life onset Paranoid Disorder, over 30 percent had significant sensory deficits, primarily deafness. Remediation of the deficits may be treatment of choice.

Suggested Readings

American Psychiatric Association, pp. 181-198.

Whanger & Myers, Chp. 6: Paranoid and schizophrenic disorders.

SESSION 6: ANXIETY DISORDERS

Overview of Session Content

The primary focus of the session is to examine the anxiety disorders outlined by the DSM-III, using the framework established during the first session, and their relationship to the elderly. Anxiety is a common problem for older adults as they face increasing demands to cope with new problems and decreasing resources upon which to draw.

Key Concepts

The DSM-III includes four groups of Anxiety Disorders:

1. Phobic Disorders: Agoraphobia with and without panic attacks, Social Phobias and Simple Phobias
2. Anxiety States: Panic Disorder, Generalized Anxiety Disorder, and Obsessive-compulsive Disorder
3. Post-traumatic Stress Syndrome: Acute, Chronic or Delayed
4. Atypical Anxiety Disorder

Anxiety symptoms (like depressive symptoms) can be considered in four general groups: somatic, emotional, cognitive, and behavioral.

Some prevalence and incidence statistics include:

1. 2-4% of the general population have a lifetime incidence of anxiety disorders.
2. 10-15% of cardiac patients are estimated to suffer a primary anxiety disorder.
3. Phobias peak around age 50.
4. Simple phobias are the most common anxiety disorder in the general population.
5. 60% of phobics seeking treatment are agoraphobic.

Common complications of the anxiety disorders include depression, self-medication (i.e., alcohol or drugs) and dependence on tranquilizers. An important differential diagnosis issue concerns anxiety disorders and medical problems. Frequently they co-exist, exacerbating one another. Chronic anxiety is believed to cause great physical damage to multiple systems.

A number of theories of etiology exist. Some of the major theories are: reactivity of the nervous system, learning theory, psychodynamic approaches, cognitive theories, the role of stress and existential views.

Treatment by medication is greatly overdone among the elderly. Behavioral approaches hold great promise, especially systematic desensitization and extinction techniques. Cognitive restructuring is another approach. Generally, the prognosis for people with anxiety disorders tends to be good with treatment, especially systematic desensitization. Without treatment, the conditions tend to be chronic.

Learning Activities/Labs

Each student is given a case study to consider as they read the assignments and assign a DSM-III diagnosis from the Anxiety Disorders. Several students are assigned to each case. The cases are then discussed in class.

Suggested Readings

American Psychiatric Association, pp. 225-239.

Whanger & Myers, Chp. 5: Anxiety disorders.

SESSION 7: SOMATOFORM & DISSOCIATIVE DISORDERS

Overview of Session Content

The session examines the Somatoform and Dissociative Disorders of the DSM III as they apply to the elderly. Special focus is upon the use of somatization to handle adjustment problems.

The Somatoform Disorders, especially hypochondriasis, are topics of special concern to mental health professionals who work with the elderly. The relationships among physical health, mental health, and somatic complaints are complex and difficult to sort out. It is difficult to separate organic and psychologically based physical symptoms. Most commonly, complaints have an etiology which may include both organic and psychological factors. Unfortunately, making the appropriate intervention depends to a large degree upon making an appropriate diagnosis.

The Dissociative Disorders are rare. However, they have been extremely popular with the media. The lay concept of "schizophrenia" is that of a "split personality", similar to the DSM III concept of one of the dissociative disorders, "multiple personality." The popularity and confusion mean that the training of mental health workers must include a survey of the Dissociative Disorders.

Key Concepts

The DSM III describes five Somatoform Disorders:

1 - Somatization Disorder

2 - Conversion Disorder

3 - Psychogenic Pain Disorder

4 - Hypochondriasis

5 - Atypical Somatoform Disorder

The DSM III lists five Dissociative Disorders:

1 - Psychogenic Amnesia

2 - Psychogenic Fugue

3 - Multiple Personalities

4 - Depersonalization Disorder

5 - Atypical Dissociative Disorder

The principal features of the Somatoform Disorders, as described in the DSM III, are somatic complaints or loss or alteration of physical functioning which reflect psychopathology rather than organic pathology. The incidence of most of the somatoform disorders among the elderly is not known. However, hypochondriasis, characterized by a preoccupation with physical illness and an unrealistic interpretation of somatic functioning, is believed to be very common among the elderly. It has been estimated that 10% to 20% of the community elderly and a much higher percentage of elderly psychiatric patients are hypochondriacal (LaRue et al., 1985).

A number of etiological factors have been suggested for hypochondriasis. It has been seen as a symptom of withdrawal from society into oneself. Another view is that it represents an attempt to cope with stress and the demands for adjustment among older people who have not developed adequate coping responses earlier in life or people for whom the coping demands of old age outstrip their more adaptive coping resources. A learning theory perspective has been taken by others. The sick role may be considered age-appropriate behavior according to our societal stereotypes and may be reinforced.

The central feature, according to the DSM III, of the Dissociative Disorders is a "sudden, temporary alteration in the normally integrative features of consciousness, identity, or motor behavior."

Most of the Dissociative Disorders are rare in the general population and extremely rare among the elderly. Little specific information about incidence or prevalence is available.

Severe stress is frequently mentioned as a predisposing or precipitating factor in the etiology of the Dissociative Disorders. The Dissociative Disorders, then, represent ways of reducing the unbearable tension. Traumatic events, such as emergency crises, may precipitate Psychogenic Amnesia, Psychogenic Fugue or Depersonalization Disorder. The stress of chronic, severe abuse during childhood is thought to be associated with Multiple Personalities.

Learning Activities/Labs

Students are given case studies to consider as they read the assigned reading and to make a tentative somatoform or dissociative disorder diagnosis. The cases are then used in class as a basis for discussion.

Suggested Readings

American Psychiatric Association, pp. 241-260.

Whanger & Myers, Chp. 7: Somatoform disorders.

SESSION 8: PSYCHOLOGICAL FACTORS AFFECTING PHYSICAL CONDITION; SLEEP DISORDERS

Overview of Session Content

The classification of Psychological Factors Affecting Physical Condition (PFAPC) is a new classification in DSM-III for the complex situations where there is a physical illness, but psychological factors are thought to be significant in initiating, exacerbating, or maintaining the condition. This might include an older person's emotional reaction to stressful environmental events/losses and its impact on a physically determined chronic condition. Some frequently encountered conditions include angina, migraine, asthma, tension headache, and low back pain. However, almost any condition can be affected.

Elderly persons often complain of disturbed sleep, and whether or not the cause for their disturbance is pathological must be determined. Often, these disturbances are of psychophysiological origin and are related to changes associated with aging. In this discussion of sleep disorders in the elderly the importance of recognizing the cause of sleep disruption, how to define a sleep disorder (based on individual and normative/cultural data), and suggested treatment approaches were covered.

Key Concepts

1. DSM-III criteria for psychological factors affecting physical condition
2. Cross-cultural aspects of sleep in the elderly
3. Changes in sleep with age
4. Clarifying a sleep disorder complaint
5. Medical disorders associated with insomnia
6. Medications/chemical substances that adversely affect sleep
7. Differential diagnosis of insomnia and prevalence in young versus elderly patients
8. Treatment of insomnia

Various sleep functions that decrease or increase with progressing age include:

1. Decrease in the total amount of sleep time
2. Decrease in sleep efficiency (more time in bed for the same amount of net sleep)

3. Increase in the total amount of time it takes to fall asleep
4. Increase in the number of times one wakes up during the night
5. Increase in insomnia

It has been reported that approximately 20 percent of persons older than age 50 have problems sleeping through the night; while 20-30 percent of those age 45-70 and about 40 percent of those over age 70 have trouble falling asleep at night. Elderly men with sleep problems tend to have underlying psychological problems, but that is not often the case for elderly women.

Two aspects are to be considered in evaluating a complaint. First, the perception of inadequate sleep must be linked to some daytime consequence. Secondly, the duration of the problem is to be considered, which is important in decisions regarding treatment. Insomnias can be classified as transient, short-term, and long-term. Each has its own etiological basis with appropriate interventions.

Transient insomnia is usually the result of brief, minor situational stress. Short-term insomnia (less than three weeks) may be a result of more serious situational stress (e.g., personal loss related to family or work), an acute medical illness, onset of a psychiatric disorder, or a medication-related problem. Long-term or chronic insomnia (greater than three weeks) may require specialized evaluation and a treatment plan for the underlying problem. From the above, it should be apparent that insomnia is merely a symptom. It can be caused by or associated with any number of different factors or conditions. However, psychiatric disorders are less likely to be associated with insomnia in elderly versus younger individuals.

Relative to treatment, it must again be emphasized that insomnia is a symptom that can be associated with a number of different conditions.

Direct treatment of the associated problem is most appropriate. Thus, the treatment approaches can include antidepressants, pain killers, elimination of drugs and/or alcohol, behavioral approaches (e.g. biofeedback and relaxation training or other stress-reducing techniques), purposefully restricting time permitted in bed, altering the sleep rhythm, and select sleep-inducing medications (not affecting REM sleep).

Suggested Readings

American Psychiatric Association, pp. 303-304 and 461-466.

Whanger & Myers, p. 207-211.

SESSION 9: SUBSTANCE USE

Overview of Session Content

Substance Use Disorders and Organic Mental Disorders are often clinically related, perhaps more so in the elderly. However, in this session the consequences of substance use or abuse (an unhealthy pattern of drug, chemical, or alcohol consumption) is the central topic. The diagnostic class deals with behavioral changes associated with more or less regular use of substances that affect the central nervous system. For most classes of substances, pathological use is divided into Substance Abuse and Substance Dependence (via the DSM-III). Five classes of substances are associated both with abuse and dependence, and three classes of substances are associated only with abuse. Alcohol is a substance to which one can be addicted (dependent), or abuse.

Our concepts of substance use disorders, except for the alcohol related disorders, must be modified considerably to make them applicable to older persons. There are basically two types of older alcohol abusers: earlier-life onset and those who begin abusing alcohol later in life, often in response to aging-related losses/stressors. Medication-induced problems are common among the elderly, with most of them developing as a result of knowledge deficits on the part of the physician, patient and pharmacist. Thus, more often, substance abuse is unintentional, except in the case of the use of alcohol. This class discussion details the more common bases for substance use disorders in the elderly, as well as means for resolving substance-related problems.

Key Concepts

1. DSM-III criteria for substance use disorders
2. Alcohol abuse as a response to aging-related changes
3. Carefinding: the hidden abuser
4. Reasons for alcohol abuse in the elderly
5. Types of older alcohol abusers
6. Intervention
7. Abuse of licit versus illicit drugs
8. Patient-related medication problems
9. Professional-related medication problems
10. Changes in physiological responses to alcohol and medications
11. Abuse of over-the-counter (OTC) medication
12. Problems associated with drug-alcohol, drug-drug, and drug-food interactions
13. Intervention: things to ask the doctor, tell the doctor. Use of pharmacist as expert consultant
14. Intervention: alcohol treatment

Substance use disorders in the elderly are both underreported and underappreciated. However, very few elderly use illicitly obtained drugs.

Most substance use problems occur in relation to legal drugs (including OTC medications, prescription medications, vitamins) and alcohol.

Prevalence estimates of alcohol abuse vary by setting. As high as 20 percent of elderly individuals in general medical/surgical hospitals have been noted to have alcohol related problems; 30-40 percent of older individuals admitted to psychiatric hospitals reportedly abuse alcohol; and another estimate is that 10-15 percent of all individuals age 55 or above residing within their communities abuse alcohol. An estimated one-third are believed to have begun abusing alcohol later in life. The above prevalence estimates very likely underestimate the problem for a number of reasons, one of which includes the bases for referring to late-life onset alcohol abusers as "hidden abusers."

Most late-onset abusers use alcohol in a "self-medicating" approach to softening the consequences of increasing aging-related changes, whereas the earlier onset abuser's reasons for alcohol abuse are a result of long-term, well developed psychological problems plus more recent reactions to age-related stresses.

The elderly are extremely vulnerable to drug-related problems; problems often not of their own making. It is truly a problem of unknown proportions. It is so large it is difficult to document adequately. A number of patient-related, physician-related and culturally-related factors both contribute to, and hide the problem.

Even if the older person takes his/her medications as prescribed, and even if the right amount and kind of medication is prescribed - there are still major hidden problems; problems related to insufficient knowledge in an era of newer medications. For example, many OTC medications are usually used by the elderly and many can silently cause serious problems either alone or in combination with other drugs; and many foods and drugs should not be taken at the same time. This sounds innocuous, but is not. A listing of risk factors associated with misuse/abuse of medications has been developed for assistance in noticing potentially at-risk elderly. Often they do not know they are "at risk."

Intervention for drug use/misuse is multifaceted from professional training curricula in geriatric medicine/pharmacology, to general consumer knowledge of potential food, OTC and prescription medication reactions specific to themselves. This often also necessitates training the elderly in what to tell the physician, what to ask him/her, and how to better use a pharmacist for safe use of OTC preparations.

Intervention for substance abuse varies according to the age of onset of the alcohol problem(s). For the earlier onset, aging alcohol abuser treatment recommendations are often similar to those for younger adults: attack the drinking behavior, "attack defenses", alcoholics anonymous, more traditional individual and group therapy approaches, and occasionally, antabuse. For the later-life onset alcohol abuser, intervention centers on the psychosocial stresses of aging by placing greater emphasis on "attacking the losses", re-establishing a positive social network, developing interpersonal skills and re-establishing positive feelings about one's self. Also incorporated are alcohol self-management techniques to minimize relapse.

Suggested Readings

American Psychiatric Association, pp. 163-179 and 128-162.

Whanger & Myers, Chp. 9: Substance use disorders.

SESSIONS 10 & 11: ADJUSTMENT DISORDERS, IMPULSE CONTROL DISORDERS AND PERSONALITY DISORDERS

Overview of Session Content

These two sessions include brief examinations of adjustment disorders and impulse control disorders, but the primary focus is upon the personality disorders. The personality disorders are examined as long-standing patterns of interacting with the environment which are maladaptive and which frequently contribute to the development of other disorders.

Key Concepts

The DSM III describes five specific categories and a residual category of Impulse Control Disorders:

1 - Pathological Gambling
2 - Kleptomania
3 - Pyromania
4 - Intermittent Explosive Disorder
5 - Isolated Explosive Disorder
6 - Atypical Impulse Control Disorder

The DSM III describes 11 specific Personality Disorders which have been grouped into three clusters plus a residual category:

Cluster 1 - appear eccentric
    1 - Paranoid Personality Disorder
    2 - Schizoid " "
    3 - Schizotypal " "

Cluster II - appear dramatic, emotional or erratic
4 - Histrionic Personality Disorder
5 - Narcissistic " "
6 - Antisocial " "
7 - Borderline " "
Cluster III - appear anxious or fearful
8 - Avoidant Personality Disorder
9 - Dependent " "
10 - Compulsive " "
11 - Passive-Aggressive " "
12 - Atypical, Mixed, or Other Personality Disorder

Although the DSM III says that personality disorders often become less obvious in middle and old age, there are many cases in which personality styles may be relatively adaptive earlier in life and may only become sources of distress and significant impairment in later life. For example, dependent personality traits may have been reinforced during most of a woman's life and may have been adaptive while her husband was living. However, upon his death, she may be unable to cope adaptively. Patterns of "personality traits" are only considered to be a "Personality Disorder" if they cause significant impairment or distress.

An examination of personality traits and personality disorders can be extremely useful in planning interventions for older adults. They represent pervasive patterns of approaching problems, dealing with stress and relating to other people which have great value in predicting future behavior. The prognosis for personality disorders is extremely poor due to their pervasive nature and duration. Furthermore, individuals with personality disorders rarely perceive their own behavior to be at the root of their problem and so lack motivation to change.

Learning Activities/Labs

In advance of their first session, each student is assigned one personality disorder case description. They are responsible for bringing to class: (1) a tentative diagnostic category, (2) at least one plausible theory of etiology which "fits" their specific case, (3) other personality disorders which they considered in making the diagnosis, and (4) a list of other DSM III disorders which are frequently concomitant. Millon (1981) is a useful guide in preparing the assignment and should be made available on reserve for students' use.

Suggested Readings

Adjustment Disorders

American Psychiatric Association, pp. 299-302.

Whanger & Myers, Chp. 8: Adjustment disorders.

Impulse Control Disorders

American Psychiatric Association, pp. 291-298.

Personality Disorders

American Psychiatric Association, pp. 305-330.

Whanger & Myers, Chp. 10: Personality, marital, family, psychosexual, and sleep disorders.

Millon, Disorders of personality DSM III: Axis II

SESSION 12: CODE V AND PSYCHOSEXUAL DISORDERS

Overview of Session Content

V Codes are conditions not attributable to a mental disorder that are a focus of attention or treatment. Included are Malingering, Borderline

Intellectual Functioning, Adult Antisocial Behavior, Occupational Problem, Uncomplicated Bereavement, Noncompliance with Medical Treatment, Phase of Life Problem or other Life Circumstance Problem, Marital Problem, Parent-child Problem, other Specified Family Circumstances and other Interpersonal Problem. The potential relevance of these categories to many elderly should be apparent.

The DSM-III diagnostic class of Psychosexual Disorders includes disorders of sexual identity, functioning, and dysfunction in which psychological factors are assumed to play a major role. Problems exclusively caused by organic factors are not diagnosed in this class of disorders. This session centers on the sexual response cycle and normal aging. Most sexual dysfunction in the elderly is usually in men; is not aging-related per se; and is more often prompted and maintained through insufficient knowledge, with other reasons being chronic illness and related medications.

Key Concepts

1. Earlier-life onset psychosexual disorders (DSM-III criteria)
2. Later-life onset sexual dysfunction
3. The sexual response cycle and normal aging
    - in men
    - in women
4. Sexual interest and activity in older adults
5. Intervention: defined by which phase of the sexual response cycle is dysfunctional

A very small percentage of the elderly are celibate. The frequency and desire for sexual contact of earlier years are directly related to frequency and desire in old age. Thus, motivation (or lack of it) is an important factor in "sexual dysfunction" in old age. Older people also cease being sexually active because of diseases in old age (primarily for men), and the loss of a willing or active partner (for women, primarily). The normal age-related changes in the second phase (arousal) of the sexual response cycle are too often interpreted as impending sexual dysfunction; and become self-fulfilling prophecies that come true due to performance anxiety. The same can occur with respect to the orgasmic and resolution phases of the normal and age-appropriate sexual response cycle.

Sexual dysfunction in old age often begins as a result of a lack of knowledge about sexuality. Again, needed minor adjustments are greeted as prophecies of a sexless old age. Very little is known about the incidence and types of sexual dysfunction in the elderly. Research data are flawed and sadly lacking. However, most sexual dysfunction in the elderly is believed to be related (based on clinical data) to erectile dysfunction in elderly men. However in healthy older men, arousal remains fairly intact. Beside chronic conditions and related medications, temporary organic problems can also generate lasting erectile dysfunction. A temporary organic problem may preclude arousal, which then prompts application of the cultural myth regarding sexual capacity in old age to one self. The prediction is one of sexual failure. It more often than not comes true. Another basis for arousal problems in elderly men is referred to as the "widower's syndrome." It is a combination of performance anxiety specific to a new partner and unresolved mourning.

Currently there appears to be no valid research evidence of a relationship between age and sexual dysfunction. Clinical evidence indicates that sexual problems are a significant issue for the elderly, but for different reasons for men and women. Men more often experience erectile dysfunction, and older women more often exist in a relationship absent of the couple's previous sexual behavior and interests. The bases for such more often relate to chronic physical problems (and medications) and self-fulfilling prophecies capable of existing in a vacuum of knowledge specific to the normal, aging related, sexual response cycle.

Currently, the preferred interventions for the earlier-life onset of psychosexual disorders include medication alone, or in combination with various behavior therapy approaches (including cognitive behavior therapy and aversive conditioning). Intervention for later-life onset conditions is often specific to the phase of the cycle impaired (desire, arousal, orgasm, resolution). Medication/drugs are appropriate to certain phases whereas skill and technique acquisition, relaxation techniques, cognitive behavior therapy, and thought-stopping are more appropriate to other phases. Also, couple-related exercises promoting continued closeness are helpful to the marital relationship.

Suggested Readings

Code V

American Psychiatric Association, pp. 331-334.

Psychosexual Disorders

American Psychiatric Association, pp. 261-284.

SESSION 13: DIAGNOSTIC DECISION TREES

Overview of Session Content

The purpose of this discussion is to promote the use of DSM-III and other decision trees in the differential diagnosis of issues noted among both the general population and the elderly. By teaching the value and use of decision trees, the hierarchical organization of the DSM-III diagnostic classes also becomes more apparent. In some mental disorders (e.g., Organic Mental Disorders) there is a wide range of signs and symptoms. In others (e.g., Anxiety Disorders) only a limited range of signs and symptoms is seen. For this reason, the order in which diagnostic classes are listed represents, to some extent, a hierarchy in which a disorder high in the hierarchy may have features found in disorders lower in the hierarchy, but not the reverse. This hierarchical relationship makes it possible to present the differential diagnosis of major symptom areas in a series of decision trees (see Appendix A of DSM-III).

Each decision tree begins with a set of clinical features. When one of these features is a prominent part of the presenting problem(s), the interviewer can, by a series of "yes-no" questions, rule in or out various diagnostic categories, thereby ending up in the correct "ball-park." The specific diagnosis is subsequently made in relation to sets of specific diagnostic criteria in the general classification, or "ball-park." For example, the decision may aid in determining whether a psychotic condition is functional versus organic and schizophrenic versus a paranoid disorder, but it cannot tell us which schizophrenic or paranoid disorder is appropriate. The decision trees help us locate the appropriate general classification (e.g., Paranoid Disorder) and final diagnosis is based upon specific diagnostic criteria within the general classification (e.g. Paranoia). It tells us "how to get there from here."

Suggested Readings

American Psychiatric Association, pp. 339-352.

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Chapter 6

MENTAL HEALTH ASSESSMENT OF OLDER ADULTS

Thomas A. Rich, Ph.D., S.M.Hyg.
Chair, Department of Gerontology
and
Director, Center for Applied Gerontology

Susan Turner, Ph.D.
Psychologist
Private Practice

COURSE DEVELOPMENT CONSULTANTS

Beverly Burton, M.A.
Department of Gerontology

Mary Morgan, Ph.D.
Staff Psychologist
Bay Pines Veterans Administration Medical Center

GEY 6616

MENTAL HEALTH ASSESSMENT OF OLDER ADULTS

Course Objectives

1. To introduce basic principles of test construction and development
2. To provide an intensive study of existing assessment instruments
3. To provide supervised clinical experience in the use of assessment instruments
4. To provide supervised experience in the analysis of test results in relation to case management, professional, and ethical concerns

Course Description

Content:

1. Basic principles of psychometric evaluation and the purposes of assessment
   a. validity and reliability
   b. standardization of administration
   c. interpretation, norming groups
2. Ethical issues
   a. confidentiality
   b. competence
   c. voluntary/involuntary participation
   d. loyalty to client/referral source
3. Scope of evaluation
   a. clinical assessment

    - b. functional assessment

4. Evaluation techniques
    - a. interviewing skills
    - b. history taking
    - c. screening instruments
    - d. ADL evaluation
    - e. behavioral assessment
    - f. environment assessment
5. Report writing

This course is presented through lectures, discussion, and experiential learning. Specialists representing different approaches to assessment serve as guest instructors. Students will administer assessment instruments and practice analysis interpretation and report writing.

The students are evaluated through a mid-term examination emphasizing content and through a final examination which tests the ability to integrate assessment and behavioral findings into a report describing the client.

SESSIONS

SESSION 1: INTRODUCTION - PURPOSES OF ASSESSMENT, LIMITATIONS AND CONSIDERATIONS

Overview of Session Content

The first class is organizational and provides an introduction to the perspective to be developed concerning the function of assessment. An understanding of the aged person within the context of the social environment as well as the test situation is emphasized. The client, the environment, the assessment instruments, and the assessor all affect conclusions drawn from test data obtained from an elderly individual. The importance of incorporating assessment results with other available data including medical history, social history, and family interviews is also introduced.

Key Concepts

1. It is important to understand the beliefs and attitudes of the person making the assessment and the effect this may have on the results.
2. Distinction is made between chronological age and functional age with recognition of wide variability in skills within elderly individuals.
3. The reasons for assessment include making a diagnosis to develop intervention strategies to aid the individual in making an important life decision, such as in career, education, retirement, and, generally, the same reasons that apply to other adults.
4. The relationship of physical health status to functioning on the assessment instruments must be carefully considered.
5. The impact of visual, hearing, and hand mobility impairments or any other physical impairments that might affect test administration must be considered at all times.
6. Fatigue as a factor influencing apparent functioning must be carefully considered, particularly with older individuals who may have chronic disease or other problems.

7. Review of some literature on motivation and the impact of motivation on the assessment process is discussed.
8. Interpretation of psychological assessment and some of the limitations based on the lack of appropriate age norms is presented.
9. An explanation of cognitive assessment is introduced here along with some of the uses of such an assessment, for example, differential diagnosis to clarify a question of dementia.
10. Psychological tests to be discussed later in the course are mentioned briefly as introductory material at this point. These include the Wechsler Adult Intelligence Scale, neuropsychological testing, memory testing, personality testing, and the wide range of functional assessment tests.

SESSION 2: PSYCHOMETRICS: NORMS, STANDARDIZATION, RELIABILITY

Overview of Session Content

The purpose of this session is to introduce the student to the functions of the measurement instruments currently and most commonly used in gerontology. This information comes in large part from the text, Kane & Kane (1981), and also from Anastasi (1982). The points emphasized in Kane & Kane as functions of an instrument include description, screening, assessment, monitoring, and prognosis.

Key Concepts

1. Assessment instrument reliability and validity
2. Norms, both developmental and within-group, how they are constructed, and their importance in test interpretation

3. Statistical concepts basic to understanding norms and test construction including frequency distribution, measures of central tendency, derived scores, and the normal curve
4. Measures of variability useful in understanding test results including descriptive terms such as range, standard deviation, percentile, and skewed curve
5. Mental age and how it is derived
6. Standard scores and their interpretation
7. Reliability is expanded in discussion of test/retest, alternate form, split half, coefficient alpha, and scorer reliability
8. Differences between power and speed tests and the relationship to older persons

Suggested Readings

Kane & Kane, Chp. 1: Uses and abuses of measurement in long-term care.

SESSION 3: BEHAVIORAL ASSESSMENTS USED IN A RESIDENTIAL AGING PROGRAM

Overview of Session Content

This week continues the discussion of concepts of validity, test scores and norms to reinforce the materials presented in the past session. It was emphasized that all procedures, for example, for determining test validity are concerned with the relationship between performance on the test and other independently observable facts about the behavior characteristics under consideration. Content validity is discussed along with face validity, criterion related validity, and construct validity (Anastasi, 1982).

Key Concepts

1. Include the further examination of different kinds of validity.
2. Content validity, the systematic examination of the test content to determine whether it covers a representative sample of the behavior domain to be sampled
3. Face validity refers to whether a test looks valid. Its importance in building rapport with client is discussed.
4. Criterion-related validity, both predictive and concurrent. Common criteria used in establishing validity such as academic achievement, special aptitude tests, job performance measures, the use of contrasted groups, and the correlations between a new test and previously available tests
5. Construct validity is the extent to which a test measures a theoretical construct or a trait is explained.
6. Examples of the many kinds of tests are provided and discussed.

Suggested Readings

Anastasi, App. C: A suggested outline for text evaluation.

SESSION 4: ASSESSMENT INSTRUMENTS IN USE IN A COMMUNITY MENTAL HEALTH CENTER: PLUTCHIK, SPMSQ, DEPENDENCY RATING SCALE

Overview of Session Content

This session is a continuation of the material concerning the variety of tests and their use in the assessment process. Emphasis is placed on the instruments presented from the viewpoint of the community mental health center and some of the features of test construction discussed earlier.

Key Concepts

1. Importance of feedback, communication, and level of abstraction in assessment
2. Discussion, description, and demonstration of the Plutchik Geriatric Rating Scale, a behavioral rating scale
3. Demonstration of the Short Portable Mental Status Questionnaire (SPMSQ), a measure of functional cognitive status; useful in screening and used in many clinics
4. Discussion of case histories where Plutchik was administered as part of the evaluation
5. Review of the Goff Dependency Rating Scale and its usefulness in the mental health center.

Learning Activities/Labs

1. Exercise demonstrating the subjectivity of historical accounts and its effect on report writing
2. Instruments used:
    a. Plutchik Geriatric Rating Scale - an objective behavioral rating scale including the areas of physical ability, verbal communication, self-care, and social behavior
    b. Short Portable Mental Status Questionnaire (SPMSQ) - a multidimensional questionnaire which assesses intellectual ability in terms of remote and recent memory
    c. Goff Dependency Rating Scale - a scale which rates one's level of functioning in terms of ADL skills and intellectual abilities

Suggested Readings

Kane & Kane, Chp. 2: Measures of physical functioning in long-term care.

SESSION 5: FUNCTIONAL ASSESSMENT DESCRIPTION AND DEMONSTRATION

Overview of Session Content

In this session a gerontologist familiar with home and clinic functional assessment demonstrates the Functional Assessment Inventory developed at the Suncoast Gerontology Center and provides information concerning its development and its value in planning for interventions and assistance for the client.

Key Concepts

1. Functional Assessment Inventory (FAI) which measures function in the following areas: social, economic, mental health, physical health, and ADL
2. The Short Portable Mental Status Questionnaire (SPMSQ) in relation to the FAI and its usefulness as a screening instrument. This information reinforces that from the previous week.

Learning Activities/Labs

1. Exercise - demonstration of the FAI
2. Instruments used:
    a. Functional Assessment Inventory (FAI) - a multidimensional instrument which assesses the mental and physical health, social, economic, and ADL status of the client

b. Short Portable Mental Status Questionnaire (SPMSQ) - discussed previously

SESSION 6: THE DEVELOPMENT OF A NEW SCREENING INSTRUMENT - A DEMONSTRATION AND DESCRIPTION OF THE ISSUES

Overview of Session Content

This week's session integrates many of the concepts previously discussed in terms of how a screening instrument to be used with the elderly is developed. This is a two part session, the second part emphasizing the continuing input concerning ethical implications for testing and the use of test results. Using materials presented in Anastasi (1982), there is discussion of user qualifications, testing instrument procedures, protection of privacy, confidentiality, and related concepts.

Key Concepts

1. Discusssion and demonstration of an instrument: Assessment of Older Adult Social Functioning (AOASF), an instrument designed primarily for use in outpatient settings by a practitioner, not a researcher or highly trained professional
2. Discussion of the document on ethical standards developed by the American Association for Counseling and Development. This document covers a wide range of settings and relationships where key ethical issues may be raised and this was a basis of discussion for the class

Learning Activities/Labs

1. Exercise - Demonstration of the AOASF
2. Instrument Used:

   Assessment of Older Adult Social Functioning (AOASF) - measures and records levels of social functioning in clients before, during, and after service is rendered. Examines the following areas of social functioning: crisis prevention and management, adjustment to chronic illness and handicaps, care of self, family relations, leisure and work, and involvement with others.

Suggested Readings

American Association for Counseling and Development, Ethical standards.

SESSION 7: GERIATRIC ASSESSMENT AND TESTING EVALUATION SYSTEM (GATES)

Overview of Session Content

This session is a demonstration and discussion of the development of a test used for pre-screening for nursing home admission. A major portion of this session is also spent on the topic of interviewing techniques and information needed by the students to develop better interviewing skills.

Key Concepts

1. Interviewing as a way of communicating information
2. Structured vs. unstructured interviewing
3. The interview as assessment
4. Explanation of material that should be gathered in a standard

intake interview with presentation of interview guide and examples

5. Basic interviewing issues for discussion
6. Introduction of a case for analysis of interview information

Learning Activities/Labs

1. Exercise - demonstration of the GATES
2. Instrument Used:

   Geriatric Assessment Testing and Evaluation System (GATES)

   - a multidimensional objective instrument which assesses functional status of the client, as well as tapping areas of environment and caregiver(s)

Suggested Readings

Basic interviewing. From James A. Haley VA Hospital, Tampa, FL
Author Unknown.

Social history format

Intake interview guides

SESSION 8: CLIENT NEEDS ASSESSMENT QUESTIONNAIRE

Overview of Session Content

This session demonstrates and introduces the students to a Client Needs Assessment Questionnaire developed at the University of Texas Health Science Center to measure functional level of client needs by providing indices of a client's functional capacity to perform in four major areas: physical health, ADL, mental health, and social resources. A revised and shortened edition developed in 1983 with a report of high reliability and validity is presented.

Key Concepts

1. The development of a client needs assessment questionnaire and psychometric issues
2. Revision and shortening including new norm groups and new reliability and validity information
3. Usefulness for service providers of such instruments, use and cautions

Learning Activities/Labs

1. Exercise - demonstration of the Client Needs Assessment Questionnaire.
2. Instruments used:
    a. Client Needs Assessment Questionnaire - a self-report of functional level of client needs in the areas of physical and mental health, ADL skills, and social resources
3. A mid-term exam is administered at this session and is structured as a short essay to determine the level of understanding of the students of key concepts presented thus far.

SESSION 9: COGNITIVE TEST - WECHSLER MEMORY SCALE, GERIATRIC INTERPERSONAL EVALUATION SCALE (GIES)

Overview of Session Content

The session first involves a discussion of the factors that affect reliability and validity of multidimensional instruments such as the FAI, GRS, and GATES. Some of the issues that affect the reliability are that most of the instruments require more than one session due to their length, some rely on data from significant others, cognitive impairment may affect results, the setting in which administration takes place is not always optimal and answers can be presented to give biased accounts on functioning. Issues that affect validity are that the client may respond in a manner which is advantageous for him/her, and that the criterion on which we assess validity, that is, clinical judgment, may not be adequate.

The rest of the session is spent discussing cognitive assessment, including approaches to cognitive test development and examples.

Key Concepts

1. Measures of cognitive functioning intelligence, orientation, memory, judgment, attention span/concentration, learning ability, and reaction time
2. Testing a single domain such as memory with rationale for testing and description of a representative instrument, the Wechsler Memory Scale
3. Discussion of rationale for subtests such as logical memory, digit span, visual reproduction, and associate learning
4. Determination of a memory quotient and its significance
5. Discussion and demonstration of the Geriatric Interpersonal Evaluation Scale with areas measured and usefulness, and the assessment process
6. Potential problems in cognitive assessment including needs for a reliable informant, problems with baseline data, and lack of adequate norms

Learning Activities/Labs

1. Instruments used:
   a. Wechsler Memory Scale (WMS) - a battery which is designed to measure memory apart from intelligence and includes the following areas: orientation, personal information, digit span, mental control, associate learning, visual reproduction, and logical memory
   b. Geriatric Interpersonal Evaluation Scale (GIES) - measures a number of cognitive domains such as temporal orientation, perceptual motor skills, recent and remote memory, and appropriate social behavior. Was developed to test the effectiveness of treatment of elderly psychiatric inpatients.
2. Exercise - demonstration of WMS and GIES.

Suggested Readings

Kane & Kane, Chp. 3:	Measures of mental functioning in long-term care.
Kane & Kane, Chp. 5:	Multidimensional measures.

SESSION 10: A TWO-PART SESSION WITH BIOLOGICAL ASSESSMENT DISCUSSED BY GUEST SPEAKER, FOLLOWED BY DISCUSSION OF THE IOWA SCREENING BATTERY FOR MENTAL DECLINE

Overview of Session Content

A recently developed test battery, the Iowa Screening Battery for Mental Decline is discussed with implications for assessment. A detailed analysis of the Iowa Screening Battery is discussed with the class, once again reinforcing the concepts of norming, sample study, reliability, validity, and the actual testing contents. The Iowa Test, in summary, is described as easy to administer, can be administered by a variety of professionals, the dementia sample was skewed toward the earlier stages of mental decline, and as useful in early diagnosis.

Discussion of information on biological assessments including neuroendocrine strategies for assessing depression, is presented.

Key Concepts

1. The importance and usefulness of understanding the client's neuropsychological status
2. The Iowa Screening Battery for Mental Decline, including normative and clinical sampling
3. The Dexamethesone Suppression Test (DST), and implications for the diagnostic assessment of depression
4. Use of electroconvulsive therapy for depression in older clients and its effect on future functioning

Learning Activities/Labs

1. Instruments used:

   Iowa Screening Battery for Mental Decline - a battery designed to distinguish cognitive changes characteristic of old age from those associated with dementia
2. Exercise - demonstration of Iowa Screening Battery

SESSION 11: PSYCHOLOGICAL TESTING: INTELLECTUAL TESTING (WAIS AND WAIS-R) AND DEPRESSION INVENTORIES

Overview of Session Content

While mental health counselors may not utilize the Wechsler Intelligence Scale in its different forms in their own practice, material from these tests is commonly found in reports describing functioning. For this reason an indepth look at the issues in psychological testing for intelligence is discussed. In addition, depression inventories are now commonly used with older persons and recognition of the depression as a major problem has become evident. Major depression inventories are discussed.

Key Concepts

1. Pseudodementia, that is, the misdiagnosis of dementia when it is really depression
2. Masked depression, symptoms of depression from the DSM III, and also discussion of symptoms of depression in the elderly as physical complaints
3. Problems in assessing depression and the definition of depression
4. Discussion and comparison of the Beck Depression Inventory, the Zung Depression Scale and the Geriatric Depression Scale
5. The Suicide Ideation Scale and its relationship to depression
6. Discussion of the Wechsler Adult Intelligence Scale - Revised, the most widely used test for assessing cognitive functioning and discussion of WAIS-R subtests, classification of intelligence, and general usefulness and problems in the assessment process

Learning Activities/Labs

1. Exercise - demonstration of the Geriatric Depression Inventory and the Zung Depression Scale

2. Instruments used:
    a. Geriatric Depression Inventory
    b. Zung Depression Scale

Suggested Readings

Kane & Kane, Chp. 3: Measures of mental functioning in long-term care.

SESSION 12: PSYCHOLOGICAL TESTING: PERSONALITY TESTING INCLUDING MMPI, RORSCHACH, THE THEMATIC APPERCEPTION TEST, THE GERONTOLOGICAL APPERCEPTION TEST, SENIOR APPERCEPTION TEST, AND THE GERIATRIC SENTENCE COMPLETION FORM

Overview of Session Content

Tests measuring factors other than intelligence, memory, or other aspects of cognitive functioning are commonly used in the general assessment of adults and older persons. This session is used to introduce the students to these tests and to the kinds of materials that they provide in understanding older persons as well as some of the problems in their use.

Relationship of the testing to personality theories is discussed, as well as strengths and weaknesses of personality testings.

Key Concepts

1. Personality is generally stable throughout life span
2. The Minnesota Multiphasic Personality Inventory is described and discussed in terms of validation process, its scales, and what it purports to measure.
3. Rorschach discussed in terms of its development and what it

purports to measure.

4. The Thematic Apperception Test discussed in terms of its development, administration of what it purports to measure.
5. The Gerontological Apperception Test and Senior Apperception Test are discussed in terms of what they purport to measure and their usefulness.
6. Sentence completion tests and their use in the assessment battery are also used.
7. A weakness of personality tests is that there are little normative data with the elderly.

Learning Activities/Labs

1. Exercise - demonstration of the Geriatric Sentence Completion Test and inkblot (projective)
2. Instrument used:
    a. Geriatric Sentence Completion Test.

Suggested Readings

Poon, Chp. 2: Clinical psychological assessment of older adults.

SESSION 13: REPORT WRITING

Overview of Session Content

An audiotape of a diagnostic interview is played and a presentation of test results is given with class discussion. This is the major introduction to integration of all materials into reports that can be useful for understanding the older client.

No key concepts are available since this is essentially an experiential class with discussion of the taped interview.

Learning Activities/Labs

1. Exercise - audiotape of diagnostic interview followed by discussion
2. Instrument used:

   Rush, A.J. (Speaker). (1982). Diagnostic interview techniques for short-term therapy of affective disorders (audiocassette). New York: BMA Audio Cassettes.

Suggested Readings

Kane & Kane, Chp. 6: Choosing and using measurements in geriatrics: Recommendations and conclusions.

SESSION 14: ASSESSMENT BATTERY AND LECTURE ON REPORT WRITING

Overview of Session Content

This session is designed to bring all the materials together from the course in terms of understanding the total assessment battery. This includes the interviewing, selection and use of assessment instruments, report writing, and preparation for the final examination which would be a test of the student's ability to synthesize. Considerations in report writing were outlined and discussed (Sattler, 1982). A written test report of the case presented the previous week is handed out to and critiqued by the class.

Key Concepts

1. Material in the testing report should pertain to the referral question, should convey the client's individuality, and should reflect any unusual behaviors and attitudes.
2. Notation in report of any conditions that may help explain test

performance

3. Common pitfalls to avoid in report writing are discussed, such as omitting irrelevant information and hearsay, abbreviations, vagueness or being too abstract, and keeping technical matters to a minimum

Learning Activities/Labs

1. Exercise - Class critique of handout of a testing report, as well as a written report of the same case.
2. Assignment - Class is assigned a report to write based on last session's diagnostic interview and background information. This report is discussed in this week's session.
3. The final examination includes a case report with background information, reason for referral, and test results of assessment instruments. The class is required to provide behavioral observation of the testing and then to integrate all of this information and submit it as a written report, with recommendations.

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Chapter 7

GERONTOLOGICAL MENTAL HEALTH COUNSELING I

Calvin Pinkard, Ph.D.
Chair, Department of Rehabilitation Counseling

James R. Moon, Ph.D.
Assistant Professor and Director, Residential Aging Program
Department of Aging and Mental Health
Florida Mental Health Institute

COURSE DEVELOPMENT CONSULTANT

Randa Robinson, M.A.
Assistant Project Director, Community Care for the Elderly
Neighborly Senior Services

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GEY 6617

GERONTOLOGICAL MENTAL HEALTH COUNSELING I

Course Objectives

1. To introduce individual counseling strategies with older adults
2. To develop an in-depth understanding of client-centered therapy
3. To examine the major research findings in counseling older adults
4. To examine the ethical and legal issues associated with counseling older adults
5. To develop an increased awareness of attending to self and older adults
6. To build skills related to establishing and maintaining a counseling relationship
7. To demonstrate the ability to communicate empathy, acceptance, positive regard, and warmth
8. To learn (understand) how to confront and challenge without alienating the client
9. To learn how to shape behavior using learning theory models
10. To demonstrate proficiency in using cognitive restructuring, imagery, and centering

Course Description

The fundamental goal of the course is to teach basic counseling skills. Two models of therapeutic intervention are presented: a client-centered

intervention and a behavioral intervention. Initially, the students are immersed in the client-centered approaches of Carl Rogers.
The purposes of these first classes are to: 1) teach self-awareness skill, 2) teach the basic notions of empathy, warmth, and genuineness, and 3) teach the basic counseling skills of listening, reflecting, labeling, and explaining.

Next, the students are taught the fundamentals of learning theory and the special considerations needed for the facilitation of learning in an elderly population. At this point, four specialized behavioral techniques are taught using practice sessions where some students role-play elderly clients while others role-play counselors. The four techniques taught are: 1) cognitive-behavior modification skills, 2) interpersonal social skills, 3) problem-solving skills, and 4) relaxation skills.

Finally, the students present audio tapes of actual "counseling" sessions with older adults. These tapes are critiqued in small discussion groups. Discussion of these tapes provides feedback to the students regarding their counseling skills and strategies.

SESSIONS

SESSION 1: ORIENTATION TO COUNSELING

Overview of Session Content

The first session begins with an in-depth introduction to the students using techniques described in the following narrative section. This exercise sets the stage for discussion of the idea that the counselor is the heart of counseling. Justifications for counseling are then presented, followed by an overview of counseling outcomes.

Key Concepts

1. Importance of personal counselor attitudes and beliefs techniques
2. The power of expectation in human experience
3. The role of expectation in counseling, citing various research studies
4. Non-verbal communication and its influence in the counseling experience
5. Demonstrations from research that illustrate the impact of counseling

A. Introduction of Students - Verbal/Nonverbal

Counseling begins before people are introduced. It starts with what you bring with you to the experience -- your expectations, desires, hopes.

Anecdotal information plus findings from research literature show the dramatic influence of expectations on human experience. What you expect to happen often becomes a self-fulfilling prophecy. For example, Albert Schweitzer writes about a patient he was treating at his hospital in Africa. It seems that the man was recovering well after his surgery until he learned that he had been fed some fruit that was taboo in his tribe. His condition deteriorated and he died within a few days. The story is also told of the court jester who incurs the disfavor of the king and is sentenced to the guillotine: the king had the apparatus rigged so that the blade would stop just before it reached the jester's head, and as you might predict, he died from the shock of expectation.

Findings from the research literature offer evidence that is not as spectacular as some of the anecdotal incidents mentioned above. However, they are perhaps even more impressive in documenting the strength of preinformation or expectation on outcome. Rosenthal and Rubin (1978) reviewed 345 studies concerning interpersonal expectancy effects and, among their reviews, they quote from the Pygmalion experiment and from animal studies using the maze and Skinner box. In the Pygmalion experiment, children in 18 sixth grade classrooms were given what was referred to as a test for intellectual blooming and teachers were told which of the students, based on test findings, would be expected to make remarkable gains in intellectual competence during the next eight months of classroom work. The study was designed to control for actual ability level so that in reality the only difference between the experimental and the control group was in the mind of the teacher. All children were retested eight months later with the same IQ tests and those children from whom the teachers had been led to expect greater intellectual gains showed significantly greater gain in IQ than did the children in the control group. In animal studies using rats, one group of experimenters was told that their rats had been especially bred for maze-brightness and the other group was told that their rats had been bred for maze-dullness. In reality, unselected rats had been randomly assigned to both groups and at the end of the experiment, the results were clear in that rats that had been trained and tested by experimenters expecting brighter behavior showed significantly superior learning compared to rats run by experimenters expecting dull behavior.

Other literature from counseling practice shows that one important factor in successful counseling outcome is the attitude of the therapist toward the client. If he believes that the client will improve, there is an increased likelihood that this will happen. The reverse occurs when he expects that the client will make no progress. These same findings have been discovered in research studying client expectations.

(At this point both faculty and students are asked to talk about expectations they have concerning the present course.)

This first class meeting affords a unique opportunity to begin teaching counseling skills such as empathy and approaches to initial contact emphasizing both verbal and nonverbal components. One way to go about this is to begin the process of getting acquainted by asking students to get into pairs and carry on a conversation speaking only in numbers. After a few minutes, they are asked to select a different partner and, this time, sit back to back on the floor while the instructor suggests various messages that might be communicated non-verbally such as "send a message of hello to your partner," "say something about the weather today," "send a message of mild annoyance," "give a message of gentle concern," "tell your partner a joke," "next, say anything you want to say to your partner followed by saying good-bye." A final non-verbal task could involve asking them to again get into pairs with someone they have not been with before and to sit facing each other, preferably on the floor. The task involves asking members of each pair to alternately practice on a non-verbal level, allowing their partner to come into them through imagination, followed by practice keeping the other person out or at a distance. During this exercise they are asked to try to get a sense of the whole person rather than just engaging in eye contact or attending to facial expression.

The above consciousness raising experiences involving non-verbal communication may be followed by asking class members to again get into new pairs and "spend about ten minutes with your partner getting acquainted so that you might introduce that person to the whole group."

B. What is happening in modern society, especially among older people, that justifies the existence of mental health counseling professions?

Estimates such as the following may be cited: 85% of illnesses are considered to be emotionally based. In the United States, 25 million people have high blood pressure, 8 million have ulcers, 95 million people drink, 65 million smoke cigarettes, and 20 million smoke marijuana. Among people who drink, 1 in 10 becomes an alcoholic. Two hundred million prescriptions for tranquilizers and sedatives are written each year. Fifteen percent of the adult population are considered to be depressed to the point of requiring treatment. Cancer and heart disease have been shown to be related to stress. Between 40-60% of all accidents are alcohol related. The divorce ratio at the turn of the century was 1:12 and it is now 1:1. Spouse abuse is estimated at 10 million. Approximately 15-20 thousand executives are terminated yearly because of disturbances in interpersonal relationships.

C. Counseling Outcomes

Selected studies may be cited that demonstrate the positive impact of counseling and the discussion will also include how counseling may be harmful by reinforcing undesirable behavior such as being an enabler in working or living with an alcoholic. Outcome studies in counseling generally respond that anxiety reduction was greater in treated groups than in untreated groups. There was also a self-reported increase of self-esteem among the treated group. In reviewing 25 years of research in the field of counseling, Frank reported maximum improvement in symptoms of anxiety and depression. Other studies have shown that counseling can reduce the number of days in a hospital. Business and industries report that they receive $3.00 back from every $1.00 invested in Employee Assistance Program counseling programs. EAP studies report that 87% of employees who went for services reported that they were helped; 91% said they trusted the people they saw; 95% said they would recommend the program to other employees.

Counseling is the major activity in employee assistance programs. While in 1972 there were 300 such programs in the United States, there are presently over 8,000 programs. Over half of the largest industries in the United States have EAP programs. Reports of benefits to industry are impressive.

Learning Activities/Labs

The above narrative describes a learning activity-lab format for the entire first session.

Suggested Readings

Arbuckle, Chp. 13: The counselor as a person.

Rogers, A way of being.

SESSION 2: COUNSELING EXAMPLES

Overview of Session Content

During this session students reviewed a three hour film showing Rogers, Perls, and Ellis doing therapy with a client named Gloria. The purpose was to give students a sense of how counseling was done by the masters and also illustrate the diversity of style.

SESSION 3: LISTENING WITH YOUR SENSES

Overview of Session Content

The general purpose of this session is to sensitize students to the process of "letting the world in" through non-verbal channels. It also provides experience in the areas of meditation, "allowing", and "letting go". These exercises have been used with older people in quality of life activities.

Key Concepts

1. Counseling begins with awareness and these experiential tasks illustrate ways to expand channels such as vision, hearing, touch, moving.
2. Pacing is critical to effective counseling with older people and these exercises help teach non-intrusive presence.
3. Fundamentals of meditation are addressed in the sense that these experiences turn attention inward.
4. The process of sensing becomes central rather than the object itself. The "how" rather than the "what" is emphasized.
5. Empathy is taught as students exchange experiences in the various sensory modes.

A major dimension of the counseling experience involves the art of listening by both counselor and client. This is a process of receiving, allowing, absorbing, letting in or being open to the world around you. Letting the world come in from the outside and being sensitive to your own inner world involves all sense modalities which act as avenues of perception. The following sensory awareness exercises are intended as consciousness raising experiences that produce more sensitive and open awareness of self and others. They are also presented as specific techniques for quality of life activities suitable for people of all age levels and especially older clients. Appropriate pacing is one of the important elements in counseling older people and sensory awareness training can be instructive in this area because it fosters an attitude of allowing, letting be, and non-intrusive presence. This type of training also overlaps meditation in that both involve a "dwelling on" component.

After each of the following activities, students should be given a chance to talk about their experiences. Charlotte Selver, Charles Brooks, and Bernard Gunther are the authors of many of the following sensory awakening methods and the procedures are described in their published works.

1. Vision: the purpose of this is to experience seeing rather than looking at something. Begin by closing your eyes; bend your fingers and start tapping around the orbit of the eyes and directly against the eyelids using a lively, bouncing, vigorous tap like rain falling for about sixty seconds. Next open your eyes as fully as possible and then squeeze them shut as tightly as you can. Do this several times. Now with eyes open let the light come in as though passing through a clear window.
2. Follow a similar procedure to practice hearing rather than listening to something. After tapping around the ears, allow the sound to come without labeling it.
3. Using fingers again, tap all over the head including the eyes, ears, face, back of the head, top and sides. Let the tapping be varied with soft touches alternating with more vigorous movement. After about 30 seconds sit quietly with eyes open and allow both seeing and hearing.
4. This exercise involves milling around. Have people stand and slowly walk in and around one another without speaking and without "grabbing" anything with their eyes or their ears, rather see and hear -- absorb and allow.
5. Sit quietly with your eyes closed and slowly bring your hands over your face so that the palms rest on the eyes and the fingers are extended

over the forehead. Keep your eyes covered for about a minute, being sensitive to what is going on inside your head and allowing whatever is happening to occur. Slowly remove your hands, attending to how you feel, and then open your eyes.

6. It has been recorded in an earlier culture that the four dignities of man include lying, sitting, standing, and walking. Have people go through each of these and as they do, attempt to experience the activity in and of itself, without any regard to outcome, such as walking to any place or sitting for a reason or standing on the floor. Awareness should be on the inner experience and the processes involved. While standing have them shift their weight slowly from one foot to the other and, as they take a step, be aware of the space they just left and the space between there and the next movement. The pace of walking may be varied with eyes opened and with them closed. Walking backwards may also be included.

7. Have people get into triads and arrange themselves so that one person stands between the other two and bend over at the waist with his arms hanging freely towards the floor. His partners will give an overall body massage that involves simultaneous slapping movements beginning with the person's hand then going up the arms, shoulders, and back and legs, down to his feet. The two people giving the massage should move as much as possible together and with the same rhythm. In turn, the other two members of the triad take the place of the person in the middle and receive the massage.

8. Each person should receive a rock about the size that can be held comfortably in the palm of one hand. While sitting on the floor place the rock in front of you and attend to it while you are relaxing. Take

the rock in your hand and see the hand as a frame behind it. Place the rock back on the floor and move around looking at it from different positions. Pick it up and see if you can sense the air around it. Place it in front of you again and view it as a piece of sculpture. Place the rock on some part of your body. Notice the color. Pay attention to the shape. Lie down on your back and put the rock on your abdomen. Notice what your body feels under the rock. Place the rock on your chest and make it a part of your breathing. Place it on your forehead. Put the rock under your head. Place it under each shoulder. Put it under your back and roll gently back and forth feeling its weight. Smell the rock. Taste the rock. Place the rock in front of you and imagine yourself as the rock. Exchange your rock with someone else in the group and for a time explore that rock. Get your rock back and send it a message of appreciation for having been with you.

9. Get into pairs and have one member lie flat on the floor on his back. The partner will sit at his feet and very slowly and sensitively raise the right leg a few inches, lifting at the heel. Move the leg from the socket slowly in a small circle and then circle in the other direction and then place it gently back on the floor. Follow the same procedure with the other leg and then move to each arm and finally the head. Have the partners change roles and go through the procedure again.
10. Have the group members get in a circle and lie flat on their stomachs and then slowly crawl toward the center of the circle making a pile in the middle.

Learning Activities/Labs

The above narrative is a description of a laboratory - learning activity approach.

Suggested Readings

Sense Relaxation - Gunther

SESSION 4: ALTERED STATES OF CONSCIOUSNESS

Overview of Session Content

Meditation and exercise have been demonstrated to reduce stress, anxiety and depression as well as contribute to an overall feeling of well being. This session introduces students to meditation and related altered state of consciousness approaches. Specific techniques are illustrated that are useful in both one-on-one counseling and also group work.

Key Concepts

1. Desensitization work often involves attention to breathing and ways to induce trance states as a background to specific conditioning procedures.
2. Relaxation is an unhurried, progressive sequence of "letting the body go."
3. The approach or attitude toward meditation is more powerful than the specific technique.
4. Fantasy has useful applications in meditation.
5. Specific trance induction methods are discussed such as the candleflame, chanting, and focusing.

Learning Activities/Labs

The fourth session is almost entirely a laboratory of trance induction and meditation.

Suggested Readings

The Relaxation Response - Benson

Focusing - Gendlin

Passages - Andersen and Savary

The Psychology of Consciousness - Ornstein

SESSION 5: IDENTITY IN COUNSELING

Overview of Session Content

This session is a broad spectrum approach to processes involved in discovering more about "who you are." Fantasy is the central technique for exploration of global impressions of the self along with relaxation modes. Older people struggle with role ambiguity and with meaning. These counseling approaches afford different, spontaneous views of the individual. The discoveries are often at the level of images - feelings rather than cognitive insights. They are holistic efforts to clarify identity.

Key Concepts

1. Meaning is often communicated deeply through images, metaphors and symbols. These modes are used to discover identity and identify deficits in the personality.
2. When language - memory declines, images may be used to explore the self.
3. Boundaries of the self/not-self are discussed.
4. Developmental stages are explored through the life span.
5. Discovery of the self is explored through perceptions of the family.

A struggle with identity issues is intense among both adolescents and the elderly. Role ambiguity is deeply threatening. During this period, anxiety and depression are not uncommon and suicide becomes more frequent. Studies of suicide notes left by older people show that over 75% state their life had lost its meaning. Therefore, counseling with the aged must deal with issues of existence and life sustaining values. The following exercises are intended to help discover more about who you are.

Another rationale for this type of experiential training is that counselors model values both covertly and overtly and it is important to know what is being communicated to the client. It has been written that we see things not as they are but as we are.

Following each exercise, students are given a chance to say whatever they wish to say about the experience. This processing can be valuable in new discovery beyond the immediate gains that may have occurred at the time of the experience itself through fantasy, symbol and metaphor. Group member reports may be used as occasions for mini-counseling episodes wherein the instructor/group leader becomes the facilitator and helps the person express himself more fully or to take more responsibility for what is being said or to be aware of postural mannerisms, voice tone, etc. This is an opportunity for the instructor to teach specific counseling methods as he explains what he is doing while working with a member of a group to amplify or deepen a given experience.

1. This experience involves asking group members to relax in a sitting position and close their eyes and breath normally. As they inhale, think the word who and as they exhale think the words am I. Repeat this mantra with every breathing cycle for about three minutes.
2. Have people relax in a sitting position with their eyes closed, taking normal breaths. As you inhale think the first syllable of your given name and as you exhale think the last syllable of your name. Repeat this mantra with each breathing cyle for about three minutes.

3. Ask members to get into groups of three and sit in a small circle on the floor or in chairs. Let them designate themselves as A, B, or C. A will then ask B, "Who are you?" and B will make a short reply. C will act as a recorder. This same question will be asked 25 times and C will keep track of the numbers. When this is completed, members change roles until all three have been in each position.
4. Ask members to get into a light trance state and imagine that their first name is spelled backward and they are looking up the meaning in a Martian dictionary.
5. Have group members make a fantasy composition of themselves using parts taken from different animals.
6. Take a shoebox full of small toys and spread them out in the center of the group. Each member is to select an object that he/she feels is interesting or attractive. After they become familiar with it they are to imagine themselves as that object, merging with it as fully as possible. Each group member is then asked to describe his existence and being as that object.
7. Have group members arrange themselves in dyads and in turn each member makes 20 statements aloud beginning with the pronoun "I".
8. Ask group members to sit in a relaxed position, and with their eyes closed, while listening to this guided imagery. You are walking along the sidewalk in a strange city and up ahead you notice some steps leading up to a rather large art gallery. You walk upstairs, go inside and begin looking at statues and paintings in open, lighted display areas. As you walk along one corridor you come to a large wooden door. You open this door and go into a very dimly lit room and find that you are alone. As you look around you see only one object in the room that

is over against a far corner and you walk slowly toward this object and as you get closer you recognize that it is a representation of you. Dwell on this object fully, walk around and absorb all of its features and if you wish, touch it. For a time merge with this object and experience your existence in this new form as fully as you can. When you feel finished, separate from this object and walk toward the large wooden door. As you are about to leave the room, turn around once more and look back at the symbolic representation of you.

9. This fantasy involves the individual and members of his family of origin. Imagine that you are a child living again with your family and as a group you are planning a picnic. Be as fully there as you can with the family details and after plans are made follow along toward the wooded picnic area. When you are all together in the woods and have located a place for a picnic, explore the immediate area sensing as deeply as possible all of the plant life around you. Feel a connection with this life and the earth beneath you. Suddenly in your imagination have you and all other members of your family become transformed into animals and allow the picnic experience to continue spontaneously. When it feels finished, bring that experience to a close and return to your normal waking state.

10. In this fantasy, lie on your back on the floor and after you have moved into a trance-like state, imagine that you are an atom, then a molecule, a cell, a heart, a body system, family, community, country, planet, solar system, galaxy, universe. This sequence is then reversed.

11. Imagine that you are standing in front of a mirror and you see something reflected other than yourself. After dwelling on that image

you may take a magic wand and touch it and have it suddenly transformed into something else. Repeat the process until you feel finished.

12. In your imagination, walk along a country road until you come to a place where the road is divided. One road leads straight ahead, another to your right and another to your left. In turn travel along those roads as fully as you like. First take the one to the left, then the one straight ahead and finally the one to your right.

13. Imagine that someone has suddenly taken a Polaroid snapshot of you as you are sitting in a room. Look at the picture as fully as you wish.

14. Have each member draw a mandala using white paper and colored pencils. You do this by drawing a circle however you wish and make any kind of drawing or mark inside the circle that comes to you. As best you can, allow it to happen and follow the construction along rather than any kind of purposeful, planned approach. Carl Jung used mandalas often in therapy with his patients and he considered it to be a unifying and creative experience that helped the person express wholeness and connectedness with the universe around him. Mandalas were used in primitive time by early cave men, their productions on walls have been interpreted as ways of expressing relatedness to the universe. Mandalas are seen to exist both in nature and in man-made artistic creations. A rose window is a mandala; Stonehenge is a mandala, and and so is the Aztec calendar. The pupil of the eye is a mandala and so is a galaxy. After group members have completed their mandala, ask them to sit before it and meditate. As they go deeper into their meditations, ask them to merge with their mandala and experience its fullness and depth. This may be followed by having them imaginatively

take the mandala inside their body and move it around in any way they wish.

SESSION 6: BASIC COUNSELOR RESPONSES

Overview of Session Content

This session is composed of fundamental training in listening and response skills. A film, developed by Jerome Kagan is shown that illustrates four common counselor response modes. Students practice skill building in these areas after explanation and some practice by the author.

Key Concepts

1. Cognitive listening. The basic point is to attend to the message or meaning content of the communication and learn how to say this to the client through reflection, summarizing, etc.
2. Affective listening. The feeling component of the communication is the focus of this skill area. It also comprises a beginning point for teaching empathy.
3. Exploratory responses. In this area students learn how to "keep the client talking" and facilitate exploration rather than issue statements that stop the action or enhance avoiding.
4. Honest labeling. Taking responsibility for what the counselor says is a major concentration in this skill area. Attention is given to how labels can make people disappear.

Learning Activities/Labs

The entire session was a lab approach.

SESSIONS 8-10: LEARNING THEORY

Overview of Session Content

These sessions present basic learning theory as well as the specific behavioral intervention techniques of cognitive behavior modification, problem solving, social skills training, and relaxation training. During the last half of each class the students are paired up to practice the techniques learned in that session. One student role-plays the therapist while the other role-plays an elderly client from a prepared script.

Key Concepts

1. The behavioral model for explaining behavior, its antecedents and consequences.
2. The basic techniques of cognitive behavior modification.
3. The basic techniques of social skills training.
4. The basic techniques of relaxation training using progressive deep-muscle techniques and cognitive imagery techniques.

Behavioral Techniques

Behavioral techniques are psychotherapeutic techniques which are founded on learning theory. Thus, behavioral techniques rely on the laws of learning to produce changes in people. In its most basic form learning theory describes an "ABC" model of behavior where:

A = antecedent conditions

B = behavior emitted

C = consequences of the behavior

A more complex model of behavior is the SOR model where:

S = stimulus

O = organism which processes the stimulus

R = response to the stimulus

If we build upon this model even further we add the Consequences component from the ABC model, (i.e., SORC). Finally, in its most complex form our model takes into account the contingencies (K) of the environment and we have an SORCK model of behavior. The SORCK model describes behavior as a result of some stimulus which is presented to an organism which is able to perceive it. Other organismic conditions include the organism's ability to respond to a stimulus. Once the organism is stimulated it generally will emit some response which will then be modified by environmental consequences and contingencies. After discussing several examples of this SORCK model of behavior, focus will shift to two major models of learning, classical conditioning and operant conditioning. Following this discussion, attention will be given to two important principles of learning, the Law of Effect and the Premack principle.

Classical Conditioning

This method of learning was first articulated by Pavlov in his famous experiments with dogs. Basically this technique involves the identification of a stimulus which always produces a characteristic response. That is, an unconditioned stimulus (UCS) produces an unconditioned response (UCR). For example, the stimulus of food placed in the mouth will always produce the response of salivation. Pavlov then found that if an unrelated event is paired with the UCS it will be able to elicit a response very similar to the UCR. Pavlov called the unrelated event the conditioned stimulus (CS) and called the similar response the conditioned response (CR). Thus, learning occurs as follows:

UCS ---------- UCR
CS - UCS ---------- UCR
CS ---------- CR

As an example, if a bell (CS) is paired with food (UCS) to produce salivation (UCR), the bell (CS) can come to elicit a response very similar to the UCR of salivation. In this case the CR might be salivation of a lesser volume of saliva than is produced with a UCS of real food.

Operant Conditioning

Another form of conditioning or learning is called operant conditioning. In this model certain predetermined behaviors are not elicited but instead are acted upon when they are emitted. Thus, when an organism emits a predetermined behavior, it could be reinforced, punished, or extinguished. Reinforcement is defined as a positive consequence applied as a result of a behavioral occurrence. For example, if you look at me and I give you 10¢ for doing so, then I have reinforced your behavior of looking at me. Punishment is defined as a noxious consequence applied as a result of a behavioral occurrence. For example, if you look at me and I hit you, then I have punished your behavior of looking at me. Extinction is defined as no consequence applied as a result of a behavioral occurrence. For example, if you look at me and I continue on with my behavior, I have extinguished your behavior of looking at me.

Generally, punishment is not used due to two major factors. First, it is generally considered unethical to use punishment as a form of treatment. Second, punishment does not have long-term effectiveness as a behavior-change technique. Generally, when the threat of punishment is removed, the punished behavior increases to above pre-punishment levels. Positive reinforcement and extinction are much more effective behavioral change techniques.

The mention of one more effective operant technique is in order, negative-reinforcement. Negative reinforcement is not the same as punishment. Negative reinforcement is defined as the removal of a noxious stimulus as a result of a behavioral occurrence. Thus, for example, if a rat passes a bar which results in a loud noise being turned off, the rat is being negatively-reinforced for bar-pressing behavior. Similarly, each time we humans put on a pair of sunglasses to reduce the effects of bright sunlight, we are being negatively-reinforced.

Law of Effect

This important law states that behaviors which are followed by positive consequences are more likely to be emitted in the future. Similarly, the Law of Effect also states that behaviors which are followed by no consequence or a neutral consequence are less likely to occur in the future.

Premack Principle

This principle states that behaviors engaged in at a high frequency can be used as reinforcement for behaviors which occur at a low frequency. This principle is often used by unsuspecting parents when they tell their children, "When you eat all of your green beans you can watch television."

Special Learning Needs of the Elderly

As we begin to apply learning principles to the elderly some special considerations need to be made. Generally, the principles which apply to learning in younger subjects apply equally to older subjects. For example, learning is enhanced by *repetition*. This is especially true with the elderly. Whereas younger subjects may need 10 repetitions to learn, older subjects may need 15, 20, or more repetitions. Learning is also enhanced by the *saliency* of the reinforcer. Younger subjects can be quite motivated by a small gold star or an extra 10 minutes of play. Older subjects generally require more salient reinforcement, e.g., a pat on the back, cheerful social praise, or other types of reinforcers which clearly stand out from the background environment. Finally, the immediacy with which a reinforcer is delivered enhances learning. Thus, a reinforcement delivered 10 seconds after the desired behavior is emitted will induce more learning than the same reinforcer delivered 10 minutes after the behavior is emitted.

The therapist of an elderly patient must therefore take the appropriate actions to reinforce learning. The therapist may find it necessary to repeat instructions and homework assignments more frequently. Also, praise and other types of therapist reinforcement and approval must be salient, i.e., it must stand out from the background "noise". Finally, the therapist must reinforce new learning as soon as possible after it has occurred. Telephone contacts and more frequent visitations may facilitate a more rapid acquisition of new material.

Frequently Utilized Behavioral Techniques

Several behavioral techniques are frequently utilized in therapy. These techniques are cognitive behavior modification, social skills training, problem-solving therapy, and relaxation training. Later we will focus on these techniques in much more detail. For now, however, they will be only briefly introduced.

Cognitive-behavior Modification

This technique is sometimes referred to as "stress innoculation". Basically, this technique assumes that internal dialogue or "self-talk" is a covert or hidden behavior which can be modified by reinforcement principles. Further, this technique assumes that the internal dialogue represents our major or predominant feeling-state. Thus, when we are depressed we have depressive self-talk. When this cognitive behavior (depressive self-talk) is modified or changed to non-depressive self-talk, the depression goes away.

Social Skill Training

It is important for human beings to adequately interact with other human beings. While some of us seem especially skilled at interpersonal behavior, others of us seem shy, uncertain, or otherwise inadequate in social interactions. The components of socially skilled behavior have been extensively delimited and are readily amenable to learning technology. The social skills techniques have been successfully applied to a wide variety of mental health problems.

Problem-solving Therapy

It is essential for clients to be able to solve their own problems in a competent manner. Problem-solving is a skill which can be taught and learned as a useful therapeutic tool for enhancing the ability of clients to solve the many problems they routinely encounter.

Relaxation Training

The ability to physically and mentally relax is an important one which has numerous benefits. Relaxation is a powerful yet simple technique which can enhance the effectiveness of other modes of therapeutic intervention. Relaxation training usually consists of a physiological component such as progressive deep-muscle relaxation and a psychological component such as cognitive imagery.

Operationalizing Psychological Problems

Often mental health professionals have a clear understanding of a psychopathological construct but a hazy understanding of the actual problematic behaviors. Thus, therapists talk quite cogently about "schizophrenia", "paranoia", etc. Yet, the questions of "What is really the matter?", and "What can I do now?", go largely without clear and concise answers. This should not come as much of a surprise since the psychopathological constructs really represent a constellation of numerous maladaptive overt and covert behaviors. Thus, treatment questions should not be of the form, "How do I treat schizophrenia", but should be of the form, "How do I treat the poor social interactions which are a part of this schizophrenic process?"

Purpose of Operational Definitions

Operational definitions specify the problemmatic behavior in such a way that the behavior can be reliably measured and observed. As such, operational definitions help to objectify behavior and help to make the behavior quantifiable. When behavior is specified in objective and quantifiable terms, it can be reliably measured over time and thus we can determine if our treatment has been effective. Of course, operational definitions carry the penalty of acting as blinders by limiting what we observe. If, for example, an operational definition does not specify "crying" as a component of its operational definition of depressed behavior, then "crying" by definition is not a part of depression.

Collecting Baseline Data

Baseline data are the data collected after a behavior has been operationalized but before a treatment plan has been put into effect. The baseline is an important part of demonstrating behavior change since the baseline will be compared to the data gathered after a treatment is implemented. As a result of this comparison, therapists make a judgment regarding the treatment's effectiveness.

Measuring Change in Behavior

Since the essence of any form of psychotherapy is the induction of change, it behooves the therapist to know how and where to look to determine if in fact change has occurred. There are two general methods by which individual change can be observed; the ABA design and its variants and the multiple baseline design and its variants.

The term "ABA design" refers to the phases in which treatment is delivered. The A-phase is generally the baseline phase, the B-phase is the treatment phase, while the second A-phase is the return to baseline phase. Most often, therapy is conducted in an A-B fashion. However, at times it is very useful to conduct treatment in an ABAB fashion. In this approach the therapist can have a much higher degree of confidence in the effectiveness of the treatment if the client improves then returns to baseline, then improves again with the reintroduction of treatment. By comparing the A-phase of treatment with the B-phase of treatment, the therapist can learn whether the treatment is having its desired effect.

Another way of measuring change is by using a multiple baseline design. As the name implies, multiple baselines on presenting problems are started at the beginning of treatment and each baseline continues while treatment is started systematically for each problem. Thus, a client might have the presenting problems of anxiety, depression, and marital difficulties. The therapist starts collecting baseline data on all three problems then devises and implements treatments for each of the problems in succession. In this way the therapist can determine the effectiveness of each treatment technique on each problem. Therefore, using the above example, the therapist may find that as the marital difficulties are resolved, the depression lifts, but the anxiety remains the same. Hence the therapist need not introduce a treatment for depression. A treatment for the anxiety however, would still be indicated.

Cognitive-Behavior Modification Techniques

This technique has as its premise that cognitions or thoughts are behaviors which can be modified by establishing laws of learning. Further, it is asserted that our subjective feelings are influenced largely by our cognitions. In other words, a person who feels depressed feels that way due to depressive cognitions. The therapist who uses this approach first has the client identify the maladaptive cognitions and track them over time usually in the form of a thought or feeling diary. Then the client is prompted to identify the onset of these cognitions and modify them in some way. Finally, the client is instructed to engage in some type of self-reward for using the technique.

A particular type of cognitive behavior therapy is the stress-innoculation technique developed by Donald Meichenbaum. In this technique the client is taught to identify the occurrence of maladaptive cognitions (also called "self-talk"). The client is then instructed to stop the maladaptive self-talk and replace it with more adaptive self-talk, e.g., replace "I can't stand it", with "This isn't good but I've handled worse things. I'm not going to let this get to me." Once the client has substituted the internal dialogue of maladaptive self-talk with adaptive self-talk, the client is prompted to engage in some form of self-reward to help ensure the likelihood that this strategy will be used in times of future problems. Finally, the therapist works with the client to anticipate future stresses and rehearse cognitive strategies the client might utilize to overcome the effects of the stresses. In this way the therapist "innoculates" the client to future problems by developing the client's "resistance" to a "weakened form" of the stressor.

This technique should now be demonstrated using a role-playing scenario. The instructor should model the approach and then have a student therapist practice the approach.

Social Skills Techniques

Socially skilled behavior refers to a set of interpersonal behaviors which permit one individual to interact in a competent and effective fashion with another. Research has shown that socially-skilled behaviors can be readily operationalized and taught to those lacking the skills. The term "social skills" is often confused with the term "assertiveness skills" and the two are used synonymously. However, assertion skills are really a subset of the more general social skills. Although there is no one universally accepted set of social skills, most researchers and therapists in this area agree on several basic components of social skills. These components include: 1) the ability to make appropriate requests; 2) the ability to refuse inappropriate requests; 3) the display of appropriate affect; 4) good eye contact; 5) the ability to disallow interruptions; 6) the ability to refrain from interrupting; 7) the ability to disallow irrelevant comments; 8) the ability to refrain from making irrelevant comments; and 9) the ability to compromise only if it is warranted.

The instructor will demonstrate the social skills technique via coaching, modeling, and using role-playing scenarios.

Problem Solving Techniques

The ability to efficiently and effectively solve problems is important if one is to quickly solve problems which threaten one's mental health and well-being. D'Zurilla and Goldfried were able to identify a group of individuals who were considered to be good problem solvers. The researchers were then able to delineate the skills needed for effective problem solving.

Finally, D'Zurilla and Goldfried found that they could teach these skills to other subjects which resulted in an increase in the subjects' abilities to solve problems.

The problem-solving approach involves five steps. First, good problem-solvers have an adaptive attitude toward problems. Rather than view problems as catastrophes to be avoided, good problem solvers view problems as a normal part of living. Additionally, good problem-solvers resist the urge to do nothing when faced with a problem and they avoid the urge to act on impulse when faced with a problem.

Second, the good problem-solver clearly defines and delimits the problem. That is to say, the effective problem-solver clearly operationalizes the problem. The adage "You can't fix what you don't know is broken", applies here.

Third, the effective problem-solver generates a multitude of potential solutions to the problem. Three rules apply when in this stage. Rule 1: Do not critique a potential solution in this stage. Rule 2: The more solutions generated, the better. Rule 3: The more bizarre or outrageous a given solution is, the more likely one is to discover an effective solution.

Fourth, effective problem-solvers choose a solution from the pool of probable solutions and implement the solution.

Finally, effective problem-solvers periodically check to determine if the chosen solution continues to be effective. If the solution loses its effectiveness, the problem-solver simply implements another solution chosen from the solution pool. If needed, the effective problem-solver will go back and recheck and possibly redefine the operational definition of the problem.

The instructor will now demonstrate this technique using a role-played scenario.

Relaxation Training

The ability to relax is essential to one's mental and physical well-being. The effects of stress or organisms are quite well-known. By using deep-muscle progressive relaxation combined with relaxation-inducing cognitive imagery a profoundly relaxed state can be achieved.

A demonstration by instructor will occur. Instructor will deliver appropriate precautions.

Learning Activities/Labs

The role-playing scripts are to be used in the second half of each class.

Sample Role-Play Scenario

NAME: Jim, white male

LEGAL STATUS: Voluntary Competent

AGE: 54

MARITAL STATUS: Single, never married

APPEARANCE: You are an extremely thin, well-dressed, neatly groomed individual. You are pleasant but shy.

GENERAL: You were born in Baltimore, Maryland. You were an only child and was very sheltered and protected by your parents. You moved to this area approximately 15 years ago. Until very recently you always lived at home. Your father died 5 years ago and your mother is now doing poorly in a nursing home. For the first time in your life you are on your own. You have no close friends. You completed the 11th grade and later earned a GED. You have also been extensively trained in the use of highly sophisticated computer equipment. You have a long history of gainful employment but have not worked in 5 years by the request of your mother. You are now interested in reentering the job market. You were first hospitalized in 1978 after you refused to show your driver's license to a police officer. You do not know exactly what happened. About 3 months ago you were hospitalized with what the doctors told you was "psychotic depression". You do not know exactly what that means. Lately you've been feeling angrier and more frustrated. Sometimes you take your frustration out on your mother. You recently lost a lot of weight. You have also lost your appetite. Your judgment is rather hazy and impaired. Actually, you are a heavy drinker but you refuse to admit this to anyone else except perhaps yourself. Even so, you are convinced that you don't have a drinking "problem".

BACKGROUND INFORMATION:

- You like to play chess.
- You are extremely shy and socially "backward".
- You will admit that "5 years ago" you had a drinking problem.
- You are generally in good health.
- You have no personal income. You live on what your mother gives you.
- Until very recently your mother still treated you very much like a child, e.g. you couldn't stay out late, you had to ask permission to drive your own car, etc.

SESSIONS 11-13: REVIEW OF PRACTICUM AUDIOTAPES

Overview of Session Content

Students will present audiotaped recordings of "therapy sessions" they've conducted with older adults. In some cases, the student will have had access to an actual elderly client population while in other cases the students interviewed older co-workers, relatives, friends, or acquaintances. The students are to be given feedback regarding their interpersonal styles, their "problem formulations", and their technical interventions.

Key Concepts

1. To have a purpose for asking certain questions in an interview setting.
2. To interview according to a certain format.
3. To intervene according to some plan which is guided by the problem formulation and a theoretical rationale for the problem's existence.
4. To intervene in a manner suggesting warmth, genuineness, and empathy.

Learning Activities/Labs

The students will present and/or critique each interview session.

Additional Resources

The Format for Organizing Data Obtained from Elderly Clients:

Ten Areas of Potential Problems
in
Elderly Mental Health Clients

As a device for achieving integration of data from various sources to produce a thorough conceptualization of the problem(s) and a behaviorally based treatment plan and as a device to ensure that no relevant problem area is overlooked, a standard set of topics which identifies ten areas of potential problems was developed. This set of topics can serve as both a guide for interviewing and a guide to organize therapeutic interventions. 1. Social Support System

The extent and quality of a client's social network is a very important factor to consider when evaluating a client's previous level of functioning and when planning the placement of the client for long-term community readjustment. As part of the assessment of the client's social support system, the client's marital status and marital history are determined by the interviewer. Additionally, the client's current living arrangements are evaluated. Finally, the client's previous and current involvements in social clubs, organizations, and other support groups are determined.

2. Economic Resources

When the interviewer determines the client's economic resources, several different areas are examined. The client's educational history is taken as well as the client's vocational history. The client's current economic resources are evaluated in terms of income (Social Security, pension, vocational income, etc.), expenses, and other assets such as real estate, insurance policies, investment income, etc.

3. Legal Problems

The client's current legal status is ascertained and any current or pending legal actions are assessed. When necessary the client is provided with referrals for legal assistance.

4. Self-defined Problems

The client is asked to list or report current problems which he or she would like to solve during treatment. No restrictions are placed upon the type or amount of problems the client lists. Additionally, the client is given the opportunity to specify his or her treatment goals. The client's self-defined problems and goals then become an integral part of the client's treatment plan.

5. Mental Health History

The client's psychiatric history is determined. The client's previous psychiatric hospitalizations, the length of stay, the precipitating circumstances, and the outcomes of the hospitalizations are determined insofar as possible. The client is also interviewed about the current problem(s), any hallucinatory or delusional experiences and the precipitating circumstances. The interviewer determines the client's current level of suicidal or homicidal behaviors. The interviewer inquires into any substance abuse problems currently experienced by the client including alcohol consumption, nicotine and caffeine intake, and the use of prescription and non-prescription drugs. Finally, various assessment scores are integrated into this section. These assessment scores include the Benton Test of Temporal Orientation score which gives a general index of cognitive impairment, the Beck Depression Inventory score which provides a self-report of depression, the children's form of the State-Trait Anxiety Inventory which gives a self-report of anxiety, and the Missouri Inpatient Behavior Scale and the Community Adjustment Potential Scale scores which give objectively obtained data on a number of different adaptive and maladaptive behaviors. Although these scores may be first reviewed in this section, information from them are often used to indicate progress in learning necessary skills or overcoming deficits.

6. Maladaptive Behaviors

The kinds of behaviors which have caused problems for the client in the past are determined by the interviewer. These include behaviors such as excessive isolation, agitation, confusion, lack of appetite, sleep disturbances, etc.

7. Physical Health Status

The information gathered by the interviewer is combined with information gathered by a medical person to provide a comprehensive understanding of the client's physical health status and the limitations which may be placed upon the client by poor physical health or deficient sensory systems. In addition, close attention is paid to the client's current medications and the probable effects of these medications upon behavior.

8. Social-Leisure Activities

The client is asked to report on leisure and vocational interests and activities in order to provide information regarding the client's utilization of unstructured time. Additionally, the client's use of unstructured time is continually monitored and data are gathered from interviews with collaterals.

9. Skill Deficit Areas

The client is assessed with respect to his or her problem-solving, social-skills, cognitive behavior modification, and relaxation abilities. Where the client is deficient in these basic skills they are taught through structured interventions. In addition, the client's self-esteem skills are assessed as is the client's knowledge and practice of basic Activities of Daily Living (ADL) skills.

10. Placement Issues

The client's most recent placement is ascertained. In addition, the interviewer determines the client's most desired placement and the client's most likely placement upon discharge from care. Placement is considered with respect to the client's level of independent functioning, income, and likelihood of continued community placement. Independent living and adult congregate living facilities with appropriate mental and physical health follow-up are the most frequent placements. Placements to more restrictive facilities such as state hospitals, crisis centers, or nursing facilities are to be discouraged unless absolutely necessary.

Summary

Thus, the standard problem list organizes a complex series of data into ten functional units. The treatment staff reviews information relevant to each of the ten sections to determine where problems exist and discusses the most appropriate treatment modality within the context of the treatment being provided.

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Chapter 8

GERONTOLOGICAL MENTAL HEALTH COUNSELING II

Jeffrey A. Giordano, Ph.D.
Departments of Gerontology and Social Work

Nan Giordano, Ph.D., LCSW
Director of Training and Consultation
Department of Child and Family Studies
Florida Mental Health Institute

COURSE DEVELOPMENT CONSULTANTS

Calvin Pinkard, Ph.D.
Chair, Department of Rehabilitation Counseling

Pat Stuart, M.A.
Manager, Aging Services Program
Hillsborough Community Mental Health Center

GEY 6618

GERONTOLOGICAL MENTAL HEALTH COUNSELING II

Course Objectives

1. To develop a range of advanced therapeutic skills and techniques
2. To provide an opportunity to practice and experience the acquired skills and techniques
3. To develop a sophisticated foundation of skills and techniques so that they can be applied to crisis counseling, couple counseling, group therapy, and family counseling
4. To focus the skills and techniques on intervention methods that meet the unique needs of older individuals and their families
5. To foster the professionalism and knowledge necessary for an interdisciplinary approach and collaborative clinical practice with older adults and their families

Course Description

The topics to be covered in this course are:

1. A review of basic interpersonal and therapeutic skills such as listening, empathy, observation of non-verbal communication, use of questions, as well as skill in conducting the initial intake or evaluative interview.
2. Concepts and theoretical foundations of crisis counseling.
3. Exploration of a systematic structured crisis counseling model.
4. Advanced skills directly related to crisis counseling and couple counseling, advanced empathy and facilitation of problem-solving.
5. Presentation and practice of reminiscent and life review

therapeutic techniques.

6. Conceptualization of the systems model as it applies to family and groups as a background for treatment.
7. Group psychotherapy with the aged and with specialized groups of the aged.
8. The development of skills related to group psychotherapy such as confrontation and group leadership facilitation.
9. Conceptualization of the family as a group and background on family therapy as it relates to families of the aged.
10 Specific skills relevant for family therapy such as reframing, prescriptions and sculpturing.
11. Relevant behavioral approaches based on learning theory to be taught to families as well as the aging individual.
12. Information and experience with the development of a reality orientation program.
13. Interprofessional collaboration in clinical practice.

The course design is primarily experiential and practice oriented. Lecture and discussion are used to introduce readings about skills, techniques, models, and approaches to counseling and psychotherapy. In a three-hour course meeting, the first hour and fifteen minutes is spent introducing materials related to a given model or skill, and the balance of the time is spent in a laboratory activity experiencing the technique, or skill and practicing. During the laboratory, the faculty member or, occasionally, a team of faculty members circulate. For laboratories with group and family, the practice experience is facilitated by interrupting, demonstrating, modeling, and coaching students.

Course Requirements

Students are required to prepare a case history based upon a real client currently in a mental health system. A variety of case history formats are suggested, however the student may select any one that will accomplish the objective. Students write the case history based on their interview and review of the records, making sufficient copies for all class members. During the latter sessions of the class, in the laboratory, the cases are staffed in a mock staff meeting. During this staff meeting, each member of the class must adopt a different professional role from that of a mental health counselor. They must study that role by reading materials that provide them with the perspective of that particular professional. Such perspectives are provided in Burnside (1984). Cases are then staffed with each person role-playing a particular professional providing that perspective. A "stop and go" teaching technique is used to explore the variety of conflict and cooperative measures that can take place in the staffing of a case. In addition, one's professional identity as a mental health counselor is reinforced during this experience.

SESSIONS

SESSION 1: ETHICS, VALUES, AND IDENTITY AS A COUNSELOR

Overview of Session Content

Students are asked to examine their own values as they relate to helping and change of individuals, particularly older individuals. The ethics of mental health counseling are discussed and the code of ethics of the Mental Health Counselor's Association is distributed. Students are asked to distinguish counselor or therapist characteristics from other kinds of helpers. The need and emphasis for specialized techniques that are highly refined is emphasized.

Key Concepts

1. A person's own value system with regard to change, improvement, and growth must be in conscious awareness for the effective counselor.
2. Counselors, therapists, and other professional people operate from a basic code of ethics that is directed toward the protection and benefit of the client.
3. Ethical considerations such as respecting the integrity and promoting the welfare of the client, confidentiality of the information, conflicting counselor relationships, and when an individual finds he cannot further benefit the client.
4. Professional affiliation with other clinicians and counselors.
5. The need for supervision when in the clinical role, whether it be formal or informal.
6. The responsibility to assess and evaluate the course of therapy during practice.

Learning Activities/Labs

Experiential activity provides a warm-up experience for students so that they can become familiar and comfortable with one another for future laboratory learning. In addition, a review of the course outline and introduction to the future laboratory experiences is accomplished.

Suggested Readings

American Association for Counseling and Development, Ethical standards.

Burnside, Chp. 31: A counselor's perspective.

SESSION 2: CRISIS DEFINITION AND CRISIS COUNSELING CONCEPTS

Overview of Session Content

This session focuses on crisis counseling theory and systems theory as a background for the skills and techniques that will follow. A distinction between crisis counseling and psychotherapy is made. The basic tenets of systems theory are provided as well as the relationship between systems theory and the definition of crisis. Further the student is provided with an experience in which basic interpersonal and counseling skills are reviewed.

Key Concepts

1. Distinction between developmental and situational crisis.
2. Examination of precipitating events and/or clusters of precipitating events as well as the crisis cycle.
3. Examination of the kinds of precipitating events for elderly people that could be related to developmental stages.
4. The family and network system of the aged as it relates to being a resource system or a precipitator of crises.
5. Resolution of crises without crisis counseling and levels of functioning.
6. The focus of crisis counseling on a specific, definable, and solvable problem.
7. Distinction between psychotherapy and crisis counseling in terms of duration of counseling, goal setting, and methodology, with specific attention paid to changes in behavior and problem-solving activity as differentiated from psychotherapy which may be more related to changes in the psyche with emphasis on feelings, attitudes, and personality.

Learning Activities/Labs

Students are required to conduct a short, structured intake interview with a partner for about 20 minutes. Each student has an opportunity to conduct the interview. A brief interview format is suggested for them to follow. After each interview students who have been role-playing the client are asked to rate the interviewer on a prescribed evaluation form that rates the intake interview in terms of appropriate tasks that are accomplished in the beginning, middle, and end; and the use of such skills as listening and empathy. Students are then required to share the evaluation providing feedback to their partner on the interview. Positive feedback procedures are taught and an opportunity for review of basic therapeutic and interviewing skills is provided.

Suggested Readings

Family Systems Theory and Aging, Definition of Crisis and Crisis Counseling. Differentiation Between Psychotherapeutic Techniques, Aguilera and Messick, pp. 11-23;

Family Systems Theory and Aging, Herr and Weakland, pp. 45-59.

SESSION 3: OVERVIEW OF DEDUCTIVE MODEL OF CRISIS COUNSELING AND ADVANCED EMPATHY SKILLS

Overview of Session Content

The entire model in an abbreviated form is presented to the student. The model has 6 specific steps (Giordano and Gantt, 1977). With each step there are related skills that are most effective in obtaining the tasks and goals to be accomplished. Building upon basic empathy skills and concepts of advanced empathy skills are presented. The opportunity to experience and practice steps 1 and 2 of the crisis model while using the skills of listening, basic empathy, and advanced empathy is provided in the laboratory.

Key Concepts

1. The deductive model is a cognitive model of counseling which systematically takes the client through a problem-solving process in an empathic and humanistic way.
2. The steps of the model are:
   Step 1: facts as the client presents them;
   Step 2: connecting related themes;
   Step 3: isolating major themes;
   Step 4: options and approaches to regaining a balance;
   Step 5: selecting one of the options;
   Step 6: a detailed plan for each option.
3. Counselor posture with regards to getting the client to speak freely and openly and express emotion and feelings such as frustration and anger without any judgment or restrictions.
4. Advanced empathy, methods, and skills can be achieved by "expressing what is implied and looking for the hidden message, pulling together materials, and summarizing in a systematic way to gain more depth of expression of feelings and identifying themes by connecting behavior, feelings, and thoughts."

Learning Activities/Labs

Since students will be role-playing in order to practice the counseling model, each student is lead through an exercise entitled, "Building your own elderly composite person." They are required through structured instructions to develop an older person with a crisis. They then role-play that person while their partner practices the various steps in the crisis counseling model. For each step, the step is reiterated verbally, then demonstrated by the instructor as to the appropriate skills and posture of the counselor and, lastly, each student practices that step with his partner who is role-playing an older person. Students are asked to take clinical notes with regard to both the content of the problem and to convert those notes to a systematic scheme which lists the essential facts for Step 1 and the related themes for Step 2. The same procedure is followed in Step 2 with each student having the opportunity to practice each step independently. The skills of advanced empathy are integrated into the existing skills of listening and basic empathy in the practice of steps 1 and 2.

Suggested Readings

The Beginning Stage of Crisis Counseling; Advanced Empathy Skills

Getz, Wiesen, Sue, and Ayers, Interviewing and Crisis Intervention: The Beginning. pp. 47-88;

Egan, Helping Skills in Stage 2, pp. 133-155.

SESSION 4: PROBLEM SOLVING SKILLS

Overview of Session Content

This session focuses upon skills that will facilitate problem solving by the client (Giordano and Beckham, 1982). Lecture material includes concepts and procedures that go beyond reiterating the classical problem solving model. Specific ways in which the therapist can facilitate and teach the client appropriate problem solving are detailed. Further, crisis counseling steps 3 and 4 are conceptually explained, modeled, and practiced by the students.

Key Concepts

1. Techniques for prompting the client to go beyond identification of the problem and identification of the solutions.
2. Techniques for preventing the client from locking in on a solution before adequate identification and redefinition of the problem occurs.
3. Assisting the client to state the problem in terms of what he can do and not what others can do, and to own the problem.
4. Bringing about an established list of priorities in terms of what problem needs to be approached first.
5. Examination of the various approaches to solving the problem in terms of feasibility and likeliness of follow-through.
6. Assistance in identifying restraining and facilitating forces associated with potential solutions.
7. Establishing with the client the criteria for success in approaching solutions to the problem.
8. Techniques for isolating major themes from the connected related themes that were established in the beginning of the crisis counseling session.
9. Brainstorming techniques to develop a list of options to apply to each of the major themes that were established.

Learning Activities/Labs

The lab consists of a demonstration of problem solving counseling in relation to step 3 of the crisis counseling model. Following the demonstration, each student practices step 3 with his/her partner playing the elderly person. Following each role play, the partner gives feedback to the person who is the crisis counselor. This same procedure is repeated with step 4.

Suggested Readings

Problem Solving in Crisis Counseling

Getz et al., Problem Solving and the middle segment of the crisis counseling session, pp 67-88).

SESSION 5: COMPLETION OF THE CRISIS COUNSELING MODEL

Overview of Session Content

This session consists primarily of a laboratory in which the students will be practicing the crisis counseling model from beginning to end. Steps 5 and 6 of the model are conceptually reintroduced in a single session and demonstrated. A handout of a case history of an elderly person in crisis, and the way that case history would look when conceptualized according to the steps of the model is reviewed.

Key Concepts

1. Integrating advanced empathy skills, problem-solving skills, and the tasks that need to be accomplished while using the crisis counseling model.
2. Prompting the client to choose one or two of the options for solving the first identified problem theme.
3. Keeping the client focused on that problem and the related options.
4. Helping the client to choose practical and realistic means for developing a plan to carry out the option.
5. Having the client test out the plan for each problem by talking it through with the counselor.

6. Providing the client with verbal and emotional support for follow-through and how to provide opportunity for coaching between sessions.

Learning Activities/Labs

Each student is teamed with his partner. The partner role-plays a different elderly person than the one he has been playing in the past. A prescribed role play prompt card is provided to the person playing the elderly individual. Each student is given approximately 45 minutes to conduct the entire crisis counseling model using the skills that have been presented previously. At the end of each crisis counseling model the other student provides feedback on the counselor's adherence to the basic steps of the model and his use of the appropriate skills. The instructor circulates, stopping role playing when necessary to keep students focused on the model and the appropriate skills. This process is repeated so that every student has an opportunity to go through the entire model as a crisis counselor. NOTE: At least 2 hours are necessary to complete this lab.

Suggested Readings

Case history of an elderly person in crisis. (Instructor's files)

SESSION 4: GROUP THERAPY AND CONCEPTS OF LIFE REVIEW

Overview of Session Content

Background information on the development of group psychotherapy and life review are presented. Principles of group psychotherapy are reviewed in relation to therapy with elderly individuals and their family members. Various approaches by therapists to group therapy are identified. A distinction is made between life review therapy and reminiscence techniques.

Students are given an opportunity to participate in a mock group therapy setting, using reminiscing techniques.

Key Concepts

1. Group structure, selection of members, and settings.
2. Issues relating to attendance at groups with regard to institutional settings or community settings.
3. The use of group members to facilitate discussion and therapy.
4. Introduction to leadership role of the psychotherapist.
5. Gerontological group therapy with a focus on recognition of the individual, fostering self sufficiency and independence, and promoting tranquility.
6. Definition of reminiscing and life review as a process of recalling past experiences or events as part of the psychoanalytic perspective.
7. Reminiscence as informational, event-oriented, and primarily focusing on factual material.
8. Reminiscence as a therapeutic technique in which past events, fears and anxieties, and successes and failures are reviewed.
9. Life review as a systematic study of one's past which focuses on the past and avoids current concerns.
10. Techniques used in life review therapy such as recall of reunions, recall of trips, development of scrapbooks, family picture books, and records of regaining ethnic identity.

Learning Activities/Labs

Students are regrouped into a group therapy setting and asked to role play the elderly person that they had developed earlier for use in the crisis counseling session. The therapy group is characterized as "therapeutic reminiscence." The instructor models the group therapy leadership position. Members of the group are asked to share family or ethnic tradition that still remains part of their current life. The therapist uses the group to bring out associations with the various traditions. The group is stopped from time to time and the instructor, stepping out of the therapist role, processes the experiences.

Suggested Readings

Burnside, Chp. 3: Principles of group therapy by Linden.

Burnside, Chp. 24: Group reminiscing for the depressed
institutionalized elderly.

SESSION 7: GROUP THERAPY WITH SPECIAL GROUPS AND CONFRONTATION SKILLS

Overview of Session Content

The adaptation of group therapy techniques to institutionalized groups that include individuals with organic complications, all female groups, or groups that are composed of individuals with the same diagnosis, such as depression, are explored. The use of supportive techniques to keep individuals involved in group therapy. Social and task oriented techniques as well as learning exercises appropriate for certain groups are shared. The use of confrontation skills as an advanced skill is introduced, conceptually discussed, and demonstrated (Giordano and Beckham, 1982). Students are given the opportunity to participate in a structured experience in which confrontation is the primary communication technique.

Key Concepts

1. Group work and group therapy with the cognitively impaired.
2. Expected behavior of members of a group who have dementia.

3. The use of various techniques such as more frequent breaks, reorientation, repetition, cotherapist, as necessary for specialized group therapy.
4. Introduction to the use of behavioral techniques.
5. Examination of limitations of group therapy with certain individuals.
6. Confrontation skills as recognizing the discrepancy or inconsistency between actual reported behavior and client's perceived attitude and beliefs.
7. Channeling successful past events toward problem solving and overcoming dysfunctioning.
8. An examination of various levels of confrontation and therapist choice of the level of confrontation to use.
9. Appropriate and inappropriate use of confrontation with certain individuals.

Learning Activities/Labs

Students are placed into small groups of three or four people. They are provided with instructions for a structured experience called "The Puzzle Exercise" adapted from Pfeiffer & Jones (1977). This exercise requires students to confront one another, not in a role play, but in reality about some aspect of their person. It is a form of mild confrontation. After each confrontation occurs and following the natural discussion, the group stops and examines the feelings and experiences that occurred both in being confronted, conducting a confrontation, and in observing a confrontation. It is repeated so that every member of the group has an opportunity to experience being confronted and being a confrontor.

NOTE: An additional instructor may be required for maximum learning opportunities in the processing of confrontation experiences.

Suggested Readings

Burnside, Chp. 13: Group work with the cognitively impaired.

Burnside, Chp. 21: Group psychotherapy with the elderly.

SESSION 8: GROUP LEADERSHIP, CO-LEADERSHIP AND LEADERLESS GROUPS

Overview of Session Content

Group leadership with regard to the therapist's skills, knowledge, and the functions that they have in the group are presented. Leadership decisions about the environment and the therapeutic atmosphere are reviewed. The interpersonal approach to group leadership is the focus of the leadership model. Students are provided an opportunity to lead group therapy in the laboratory section of this session.

Key Concepts

1. The importance of maximizing the therapeutic effect of the environment.
2. The interpersonal approach which emphasizes the relationship between members.
3. The leader as a model of therapy and behavior.
4. The leader's use of such techniques as reinforcement, information dissemination, and as a catalyst.
5. Advantages and disadvantages of co-therapy such as competiveness, member manipulation, differences in therapeutic techniques and notions, and dual relationship issues.
6. Functions of the group leader such as executive functions,

emotional stimulator, supportive functions, and as a source of knowledge.

Learning Activities/Labs

The lab is designed so that some of the students will have the opportunity to function as a group psychotherapist leader. The design is such that students will in a very short period of time have to change roles from being a member of the group to a leader of the group. The instructor will stop the group from time to time to process the experiences of various group leaders. In this design, the instructor begins the group, demonstrating some of the group leadership skills from the lecture. The instructor, holding a volleyball marked therapist, will pass the volleyball to some other group member, who when holding the ball, becomes the group leader. This is called "catch-a-therapist" (Giordano, 1981). Upon the signal of the instructor, the current group leader will pass the volleyball to any other member of the group and that person returns to being a group member. The ball can be passed about eight times within an hour and fifteen minute period.

Suggested Readings

Burnside, Chp. 5: Principles from Yalom.

Burnside, Chp. 9: Groys Contracts.

Burnside, Chp. 11: Problems in leadership and maintenance.

Burnside, Chp. 12: Using patients as co-leaders.

SESSION 9: FAMILY SYSTEMS AND FAMILY TECHNIQUES OF REFRAMING AND PRESCRIPTION

Overview of Session Content

The family is conceptualized as a group and group dynamics and concepts appropriate to understanding and working with families in therapy are presented. Further, general systems theory is used as it was with groups and crisis counseling as a general framework. Specific problems and considerations relevant to elder families and family systems are noted. Conceptual definition of the technique "reframing" is presented along with a description of the process. The conceptualization of the skill "prescription" is presented, as well as a description of the process. Key

Key Concepts

1. Families as a set of rules, relationships, systems and sub-systems.
2. The levels on which family rules operate.
3. Subsistence within the family, the boundaries, expectations, and roles of members.
4. The classifications of family functioning.
5. The focusing of information on the aged individual as a member of the family.
6. With the focus on the elder member of the family, such problems as scapegoating, alliances, incongruences, and conflicts between younger and older members, and role reversal are interjected.
7. Reframing as changing the client's world view to allow more alternatives or less emotional inference in the way one conducts life.

8. A presentation of the basic steps for the reframing process to include creating the reframe and the response to the reframe.
9. Prescription as a set of instructions or injunctions that the family must carry out between sessions.
10. Distinction of prescriptions from homework assignment or contracts is made.
11. A process for the delivery of prescriptions and holding families accountable for prescriptions.
12. When not to use prescriptions with families.

Learning Activities/Labs

Examples of prescriptions that are used with families of elderly individuals are presented to the class in a small group setting and discussed. Opportunities to practice reframing are provided to dyads of individuals. Prescribed role plays are used in which students are instructed as to how to use reframing with one another. Feedback from partners on their reframing abilities and class discussion of reframing follows.

Suggested Readings

Family System Theory; skills and techniques designed specifically for family therapy (Herr and Weakland, Approaching the Family System, pp 69-84; Determining the problem, 85-99; Determining attempted solutions, 100-123; Wilcoxon, Engaging non-attending family members in marital and family counseling: ethical issues, Journal article).

SESSION 10: AN EXPANDED VIEW OF FAMILY THERAPY

Overview of Session Content

Background on family therapy with some reference to historical development of family therapy is provided. Explanation of the recent development of methods exclusive to family therapy or methods that are used most frequently in family therapy. An expanded view of family as it pertains to elderly and their families is presented. Concepts of marital therapy and marital enrichment are introduced. Specific detailed information is provided on the family therapy technique of sculpting and the use of Home work Assignments. Students are given an experiential participatory learning activity in the laboratory with sculpting and are provided with a Home work Assignment to conduct out of class.

Key Concepts

1. Comprehending the family system as a therapeutic unit and the family as a group.
2. Conducting family therapy by working with one or any number of the members.
3. Engaging nonparticipatory members in family therapy.
4. Counseling with the adult children of the elderly client.
5. Inclusion of significant others as family members when conducting family therapy with the elderly.
6. Communication skills and concepts relevant to family members.
7. Issues in marital therapy for older marriages such as caretaking, extended time together, and involvement in the life of the adult children.
8. Techniques of terminating family therapy and supplementing family therapy with individual treatment.
9. Sculpting as a method of participatory involvement by the family in which they arrange one another in living statues so as to provide greater understanding of their relationships.

10. Home Work Assignment as different from Prescription, its empirical base and the components of a Home Work Assignment.

Learning Activities/Labs

Students are constituted into a group "fishbowl arrangement" in which there is an inner group and an outer group. The inner group members are designated various family roles. The instructor sculpts a family that he knows using the inner group members. Following the sculpting, students in the outer group are asked to explain to one another and to the instructor what they know about the family. The instructor can then attest to the accuracy of their observations from the sculpture with his/her knowledge of the family. This process is repeated and students are given an opportunity to sculpt their own family or a family whom they know. Usually there is enough time for two or three sculptures. The other part of this laboratory is carried out outside of class. Students are given a Home Work Assignment using all the components of a homework assignment and written out by the students. At the next class meeting students report on their experience with the Home Work Assignment.

Suggested Readings

Burnside, Chp. 19: Family sculpting: A combination of modalities.

Herr & Weakland, Chp. 12: Winding up: Giving credit and getting out.

Herr & Weakland, Chp. 18: Independence and loneliness.

SESSION 11: FAMILY TEACHING AND TRAINING APPROACHES

Overview of Session Content

Teaching and training approaches relevant to assisting family members in dealing with mental illness, emotional upset, or devastating life changes are the focus of this session. A distinction between teaching, training, and therapy is made and the student is introduced to concepts of Family Life Education, Psychoeducation, and other Structured Educational Approaches. The concepts of structured education have been followed in the construction of this course. Therefore, students are asked to review the components of teaching and learning that have taken place thus far, particularly in the laboratory section of the course. These components are identified as relevant for use in teaching family members.

Key Concepts

1. Techniques of teaching vs. techniques of therapy and the focus on behavior.
2. The relevance of the teaching approach that have therapeutic goals and the integration of therapy and teaching.
3. The basic component of the Structured Educational Approaches for a given topic are: lecture and/or discuss the concepts, demonstrate the application, and give participants an opportunity to practice application.
4. Techniques for processing educational experiences to ensure application in real life situations are shared.
5. Methods and ways to increase opportunities within the family structure for reinforcement of appropriate behavior such as providing the elderly an opportunity to do more for themselves, or challenging professional limitations placed on elderly behavior.
6. Techniques for increasing behavior that is functional in the family that could be taught to family members such as the appropriate use of praise, social attention, and touching.
7. Techniques that can be taught to family members that would decrease

behavior that needs to be eliminated by increasing incompatible behaviors through the use of reward, shaping, relaxation training, parent association.

Learning Activities/Labs

This laboratory is basically discussion in review of the Structured Education Approach components that have been used in the design of this course. The application of those components to Family Life Education and the relevance of that approach are reinforced.

Suggested Readings

Structural Educational approaches and behavioral techniques with families of the elderly (Pinkston & Linsky, Teaching behavioral family treatment to practitioners, pp 1-4; Practice and research with the elderly, pp 5-11; Assessment of the client's problem and resources, pp 13-29; Intervention procedures and guidelines, pp 33-49).

SESSION 12: BEHAVIORAL APPROACHES AND LEARNING THEORY

Overview of Session Content

A brief review of learning theory as the foundation for behavioral approaches and for teaching is conducted. Behavioral approaches which focus on the cognitively impaired elderly, that can be taught to family members and the behavioral technique of Contracting that can be used with family members for ensuring the implementation of such behavioral techniques is presented. Students are given the opportunity to experience a Contract personally by going through the process of writing the contract with instruction and fulfilling the requirements of the contract before the beginning of the next session.

Key Concepts

1. The empirical basis for learning theory and its difference from other human behavior theories.
2. The appropriate application of learning theory as a foundation for behavioral approaches.
3. Appropriate use of behavioral approaches integrated with other approaches to psychotherapy and counseling.
4. Techniques for identifying specific behavior to be targeted for change and clarifying that behavior with family members.
5. Behavioral techniques of positive reinforcement, shaping, extensions of progressive relaxation as methods the therapist can use directly with the client as well as transfer those methods to family members through structured education.
6. Relevant and appropriate behavioral approaches with regard to specific problems such as marital counseling, depression, or memory disorders.
7. Contracting as a behavioral technique that makes desirable conditions more likely to occur.
8. Contracting's use for clarifying the relationship between the therapist and the client.
9. Contracting for evaluation material or past accomplishment in the client's home environment.
10. The requirements of a good contract such as mutual consent, considerations, sanctions, consistency of strategies with goals.

Learning Activities/Labs

The basic components of a written contract are presented to the group of students. A contract that prescribes the desired behavior, the conditions under which it occurs, the reward that is available for meeting the conditions, the process for monitoring the behavior, and the reward for the contractor is made with students. Students are asked to write out the various components as presented by the instructor, sign the contract and carry out the conditions of the contract between this session and the next. At the beginning of the next session, time is given to discussing the experience that individuals had with their contract. At that time, students will have had an experience that would be similar to the experience that their future clients will have.

Suggested Readings

Behavioral techniques with family members and with elderly clients (Haley, A family behavioral approach to the treatment of the cognitively impaired elderly, Journal article pp 18-20; Pinkston & Linsky, Application of behavioral procedures to specific problems, pp 58-85; Summary: The model and its use, pp 91-95).

SESSION 13: REALITY ORIENTATION TECHNIQUES: INTERPROFESSIONAL COLLABORATION

Overview of Session Content

A review of information on the research of Reality Orientation as a technique to be used both in institutions and community day care settings. The use of Reality Orientation techniques for home use by family members is also presented. The Mental Health Counselor's place among professionals treating the elderly is experienced and simulated by the conducting of a mock staff meeting during which students present case materials that they have developed over the term.

Key Concepts

1. The appropriate use of Reality Orientation and the necessity of full participation by staff members and family.
2. Reality orientation as a process to help with memory deterioration, isolation, depression, and other withdrawal phenomena.
3. The three step process of reality orientation.
4. Training staff members and ensuring participation in reality orientation.
5. A model program is experienced.

Learning Activities/Labs

The didactic segment of this session is conducted in a quasi-laboratory arrangement. That is, the classroom or a treatment facility, if one is available, is decked out as a model program of Reality Orientation with appropriate signs, dates and verbal ques being used with class members. Class members are walked through the room (ward) and the model program is explained as they experience aspects of it. The primary lab experience for the interprofessional collaboration is one in which students are constituted into a staffing group. Each student role plays one of several professionals who are found in the treatment of mental illness and emotional problems with the elderly. Students may assume the role of psychiatric social worker, rehabilitation counselor, pastoral counselor, psychiatric nurse, psychiatrist, clinical psychologist, or medical social worker. The student presenting the case assumes the role of a mental health counselor. As cases are presented, each individual who is role playing another professional, gives the perspective of that professional relative to the case to determine the best treatment plan.

Suggested Readings

Burnside, Chp. 14: Reality orientation: A review of the literature.

Burnside, Chp. 29: A social worker's perspective.

Burnside, Chp. 30: A psychologist's perspective.

SESSION 14: PRESENTATION OF PROFESSIONAL SELF: INTERDISCIPLINARY COLLABORATION

Overview of Session Content

Students' identification as a mental health counselor and the appropriate presentation of self as a professional in making a contribution to the diagnosis and treatment of elderly individuals and their families is stressed. Team work with other professionals while maintaining appropriate decision making responsibility for case management and therapy is emphasized along with the use of other professionals as collaborators, consultants, and colleagues. Interaction with other professionals with regard to the appropriate use of language, respect for different perspectives, points of view, theoretical orientation, and methodologies are explored. The staffing experience is continued.

Key Concepts

1. Mental health counseling and therapy is seldom done in isolation without collaboration with team members, a supervisor, or colleagues.
2. The variety of professionals who apply their expertise to the elderly in a family makes for a stronger likelihood of success and treatment.
3. Presentation of self as confident and competent is an important

part of gaining the confidence of family members and the elderly individual so that they will follow through and remain motivated to change.

4. Refraining from placing one's self in a subordinate position to other professionals by not inappropriately deferring decisions, displaying lack of confidence or use of poor judgment.
5. Commitment to the concept of team work in working for the mental health of elderly and their family members.
6. Following through on one's component or segment of treatment plan as a demonstration of professional competency as an essential ingredient for respect and equality.
7. The responsibility to provide relevant knowledge and content unique to the elderly and their family members during staffing sessions or team meetings.
8. Appropriate preparation of cases for staffing and presentation of those cases at staffing.
9. When and how much to present at a staff meeting.
10. Responsibilities and assignments for carrying out elements of the treatment plan.
11. Staffings with client and family present.

Learning Activities/Labs

The staff meeting that was constructed in the previous session continues during the laboratory of this session. Students continue to present cases and they are staffed by various other students who are playing the role of certain professionals. The instructor stops the action after each case is staffed to process the current activity and to reinforce the concepts of interdisciplinary collaboration, presentation of professional self, teamwork, and the use of professional expertise from a number of individuals to maximize the success and treatment of a case.

Suggested Readings

Readings assigned for the previous session cover the areas necessary for this session. No additional readings are necessary.

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Chapter 9

LOSS AND GRIEF COUNSELING

Mary Jean Etten, Ed.D., R.N., C.D.E.
Professor of Nursing
School of Nursing
St. Petersburg Junior College
and
Adjunct Lecturer
Department of Gerontology

GEY 6934

LOSS AND GRIEF COUNSELING

Course Objectives

1. To introduce the meaning of the concept of loss and its implications for individuals during the older adult period
2. To explore the physical and psychosocial responses to loss (both typical and atypical), coping mechanisms, and available support systems
3. To examine the impact of loss upon the individual and family, adaptive mechanisms, counseling strategies for both the older person and family/significant others
4. To discuss individual and group counseling community support system as therapeutic modes in the resolution of grief as a result of loss
5. To discuss counselor loss and grief, burnout, and healthy adaptation.

Course Description

Content:

1. Definition of the meaning of loss, characteristics of the concept.
2. Historical review of the behavioral science literature addressing loss.
3. Overview of the impact of loss upon older adults relating to physical and psychosocial losses.
4. Differentiation of normal vs. abnormal grief together with

phases and coping mechanisms of grief resolution.

5. Discussion of unique types of losses experienced by the elderly such as retirement, illness and disability, financial deficits together with coping mechanisms, support systems, and cultural perspectives.
6. Death discussed as the ultimate loss, suicide, separation and bereavement; adaptations and adjustments to the role of a widow or widower.
7. The uniqueness of loss to older adults, concept of "bereavement overload", developmental losses, coping mechanisms, and support systems and methods of assisting with grief resolution.
8. The family system of older adults, dynamics, impact of loss and loss resolution.
9. Individual counseling in diverse settings with adult children and elders experiencing losses.
10. Group counseling strategies useful with elders in the resolution of grief through loss.
11. Community agencies, support services available for elders, and adult children experiencing loss.
12. Counselor responses to personal and client loss, methods of coping.

Course Design

(Ten 3-hour sessions)

This course is presented with a combination of learning strategies; lectures, discussion, examination, speakers, class sharing, and a field trip. Individual and group structured exercises are used and shared among the class.

Audiovisuals are viewed throughout the course with group discussion and critiques.

Assigned readings for each week are required, with additional suggested readings.

Students participate in five sessions with an older adult who has experienced a loss or losses. Sessions 3 and 4 are audiotaped with session 5 videotaped to share in class. The first two focus on assessing the older adult, (1) for losses associated with aging, (2) losses associated with death, suicide, or separation. These two are written. The remaining three focus on counseling for these losses. A critique is to be written for each session.

Course Requirements

Assessments, audio and videotapes. Tapes are viewed and given an S or U grade by the professor. One take home examination is given toward the end of the course.

Suggested Text

Since this course is unique, no single textbook will be used. Journal articles and chapters from several books are required or suggested.

Students are to purchase the book The Castle and the Pearl (1983) by Christopher Biffle, New York: Harper & Row, and write in it as an exercise in self-discovery and as a means of viewing their life more clearly.

SESSION 1: THE CONCEPT OF LOSS

Overview of Session Content

Review of the course, its objectives, course description, organization, and requirements. Students will introduce themselves and their background, education, personal and professional experiences with loss. Past work and future career plans will be shared. Historical review of loss and the meaning of the concept of loss is discussed.

Key Concepts

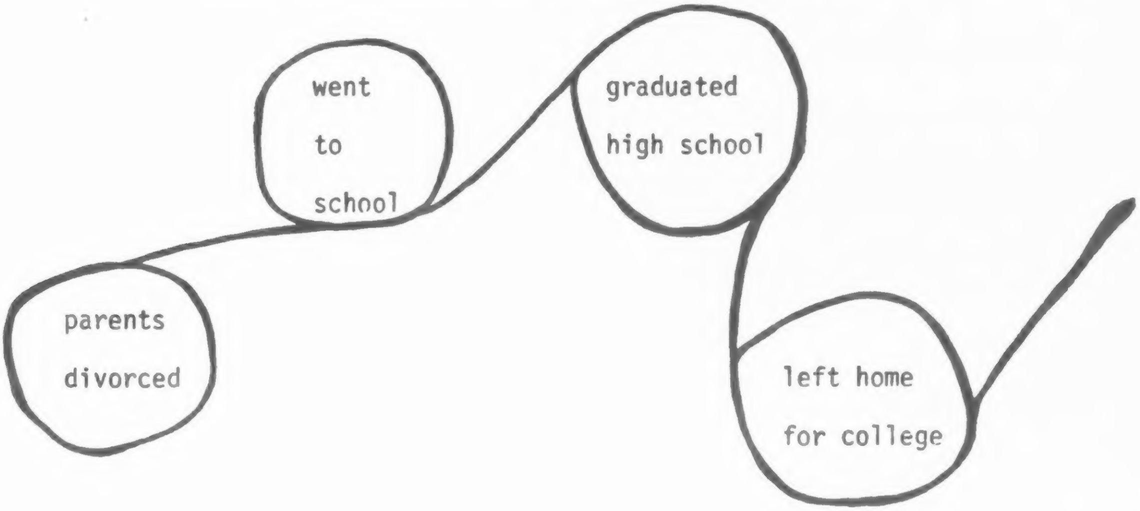
1. Description of the meaning of the concept of loss.
2. Discussion of the characteristics of loss as defined by social scientists.
3. Historical review of the concept of loss through the social, behavioral science literature.
4. Discussion of Freud's, Lindeman's, Engel's, Bowlby's, and Parks' perceptions of loss and its meaning.
5. Loss and gain exercise - a personal experience of loss and gain - reflection on life's experiences and implications. Draw a personalized loss/gain spiral and share in a group to facilitate introspection and sharing.
6. Overview of the loss experience throughout the life span.
7. Societal responses to loss; helps and hindrances.

Learning Activities/Labs

Loss-Gain Exercise

Students arrange chairs in a circle. Each takes a piece of paper and a pencil. They are asked to draw their personal losses and gains and label each that they have experienced in life.

(Example) **Losses (down) and Gains (up) Circle**


went
to
school
graduated
high school
parents
divorced
left home
for college

Each shares his drawing with others in groups of 4-6. Personal implications of the pattern of gains and losses on the individual and methods of sharing and coping are discussed.

Suggested Readings

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Lindemann, E. (1944). Symptomatology and management of acute grief. *American Journal of Psychiatry*, *101*, 141-148.

Parks, C.M. (1972). *Bereavement: Studies of grief in adult life*. New York: Basic Books.

Sullender, R.S. (1985). *Grief and growth*. New York: Paulist Press.

SESSION 2: INDIVIDUAL RESPONSES TO LOSS EXPERIENCES

Overview of Session Content

An investigation into the process of loss and its impact upon the older adult physically, emotionally, socially, and spiritually. Time sequence related to loss and grief. Overview of the normal and abnormal patterns of grieving including anticipatory grief, therapeutic approaches to grievers.

Key Concepts

1. Overview of loss experiences impacting an older person.
2. Variables relating to the unique meaning of loss for each individual older person.
3. Description of the determinates of grief resulting from loss.
4. Discussion of why individuals fail to grieve.
5. Overview of the physical, social, and psychological responses

to grief.

6. Review of the literature regarding the time sequence of grief, its phases and responses.
7. Introduction to the types of grief as well as abnormal grief responses.
8. Therapeutic approaches to assist older grievers through the grieving process.

Learning Activities/Labs

Completion of the exercise History of Losses located in the book Grief counseling: A handbook for the mental health practitioner by Wordan, J.W., pp. 110-111. Gather in groups of 4-6 and share the completed history.

Audiovisual Resources

Aging: Who is Listening, 30 minute videocassette
($60 rent, $250 purchase, film purchase $350).
Source: The American Journal of Nursing Co-Educational Services
Division, 555 W. 57th Street, New York, NY 10019-2961.

Description of the phenomenal changes older adults have experienced over a life time; the attitudes of today's society toward the elderly; significant events of the twentieth century relating to the aged.

Suggested Readings

Armstrong, J. (1985). Learning to live with a loss. Canadian Journal of Psychiatric Nursing, 26, 4-6.

Benoliel, J.Q. (1985). Loss and adaptation: Circumstances. Death Studies, 9, 217-233.

Davidson, G.W. (1984). Understanding mourning. Minneapolis: Augsburg Publishers.

Kozma, A. & Stones, M.J. (1980). Bereavement in the elderly. In B.M. Schoenberg (Ed.), Bereavement counseling: A multidisciplinary handbook (pp. 213-237). Westport, CT: Greenwood Press.

Osterweis, M. & Solomon, I. (Eds.). (1984). Bereavement, reactions, consequences, and care. Washington, DC: National Academy Press.

Rondo, T.A. (1984). Grief, dying, and death. Champaign, IL: Research Press.

Weizman, S.G. & Kamm, P. (1985). About mourning: Support and guidance for the bereaved. New York: Human Sciences Press.

SESSION 3: LOSS EXPERIENCES IN THE LATER YEARS

Overview of Session Content

Examination of the types of losses older persons experience. Changes in social roles, relocation, physical, and psychological losses including institutionalization. Coping mechanisms, adaptation, and support systems. Culturally diverse older adults and their special needs regarding loss. Counseling strategies including assessment.

Key Concepts

1. Overview of role transitions and social stress in older adults related to identity and social adjustment.
2. Transitions in middle and old age related to family systems and relationships.

3. Description of alterations in economic status and their impact on older person's adjustment to living.
4. Discussion of the sociocultural and personal perspectives regarding sexuality in the later years.
5. Special impact of illness; acute and chronic disease, and accidents on older persons.
6. Review of patterns of individual adaptation support systems and community resources.
7. Overview of counseling strategies useful with biopsychosocial losses of aging.

Learning Activities/Labs

An Adaptation to Life Crisis Model of Lieberman and Tobin (Lieberman, 1975). (Use as an exercise in the class).

Audiovisual Resources

Aging: The Losses, 30 minutes videocassette
($60 rent, $250 purchase, $350 film purchase)

Reviews the losses of family and friends, as well as the changes in living arrangements, income, role, and responsibilities which the elderly face; it stresses the need for the professional person to assist the elderly to find means of reinvestment.

Aging: Sensory Losses, 35 minutes videocassette
($60 rent, $250 purchase, $350 film purchase)

This tape details techniques for assessing the sensory abilities of the older person for enhancing these abilities so the aging adult can function more effectively.

Aging: Slowing Down, 30 minutes videocassette
($60 rent, $250 purchase, $350 film purchase)

Presents the decline in functional capacities that are part of aging and methods to assist elders in developing coping mechanisms.

These are from *The American Journal of Nursing Co-Educational Services*, 555 W. 57th Street, New York, NY 10019-2961

Suggested Readings

Agee, J.M. (1980). Grief and the process of aging. In J.A. Werner-Beland (Ed.), *Grief responses to long term illness and disability* (pp. 133-168). Reston, VA: Reston Publishing Company.

Hanson, E.I. (1980). Effects of grief, associated with chronic illness and disability, on sexuality. In J.A. Werner-Beland (Ed.), *Grief responses to long term illness and disability* (pp. 63-81). Reston, VA: Reston.

Kalish, R.A. (1985). *Death, grief, and caring relationships*. Monterey, CA: Brooks/Cole Publishing Company.

Kerson, T.S. & Kerson, L.A. (1985). *Understanding chronic illness* pp. 187-219). New York: The Free Press.

Lee, R. (1982). Object loss and counseling the bereaved. In J. Fruehling (Ed.), *Sourcebook in death and dying*. Chicago: Marquis Prof. Pub.

Lewis, K. (1983). Grief in chronic illness and disability. *Journal of Rehabilitation*, *49*, 8-11.

Miller, J.F. (1983). *Coping with chronic illness: Overcoming powerlessness*. Philadelphia: D.A. Davis.

Moulton, P.J. (1984). Chronic illness, grief and the family. *Journal of Community Health Nursing*, *1* (2), 75-88.

Pereira, B.A. (1984). Loss and grief in chronic illness. *Rehabilitation Nursing*, *9*(2), 20-22.

Rockwell, R. (1980). Counseling the elderly for sexual identity. In C.J. Pulvino & N. Colangelo (Eds.), *Counseling for the growing years: 65 and over* (pp. 81-94). Minneapolis: Educational Media.

Saldofsky, P.M. (1980). Financial counseling: General economic background and information for helping elderly clients. In C.J. Pulvino & N. Colongela (Eds.), *Counseling for the growing years: 65 and over* (pp. 131-162). Minneapolis: Educational Media Corp.

Supiano, K.P. (1980). The counseling needs of elderly nursing home residents. In C.J. Pulvino & N. Colangelo (Eds.), *Counseling for the growing years: 65 and over* (pp. 33-46). Minneapolis: Educational Media Corporation.

Werner-Beland, J.A. (1980). *Grief responses to long term illness and disability*. Reston, VA: Reston Publishing Co.

SESSION 4: LOSS EXPERIENCES THROUGH SUICIDE, SEPARATION, OR DEATH

Overview of Session Content

The meaning of life with death as the ultimate loss. Incidence of suicide among older adults and responses of bereaved. Divorce and separation experiences discussed. Loss through death: of spouse, siblings, children, peers, friends, and pets. Implications of these types of losses for older adults and therapeutic approaches.

Key Concepts

1. Compare and contrast the meanings of life for each individual vs. the meanings of death.
2. An examination of death as a loss: of experiencing, of control, of competence, of people, of things, of self, and of the capacity to complete projects and plans.
3. Examination of the meaning of suicide and its varied images and dimensions.
4. Distinguish between theoretical perspectives of suicide including psychoanalytic, existentialist, Hillman's subjectivist, and Durkheim's sociological.
5. Relate the dynamics of suicide in the later years, its implications, and effects on the survivors.
6. Discuss the implications of separation through divorce, physical separation and alienation from self, others, and God during the older age period.
7. Examination of the experience of widowhood upon the older male and female survivors.
8. Compare and contrast the loss of adult children, siblings, significant others, and pets for older adults.
9. Describe therapeutic approaches appropriate for each of the losses discussed in this session.

Learning Activities/Labs

Invite an older widow and widower to class who are willing to share their experiences of loss and grief resolution with the students.

Audiovisual Resources

Grieving: Suddenly Alone, (1982), 26 minutes videocassette

($50 rent, $240 film purchase)

Source: Churchill Films, 662 N. Robertson Blvd., Los Angeles, CA 90069

An accurate, sensitive view of widowhood during the later years. The process of grieving for the loss over time together with dynamics with family, friends, and society. Gradual resolution of the loss and reintegration into the role of a widow as a productive, new, whole person.

Suggested Readings

Cain, A.C. (1985). Survivors of suicide. In S.G. Wilcox & M. Sutton (Eds.), *Understanding death and dying: An interdisciplinary approach* (3rd ed.), (pp. 207-210). Palo Alto, CA: Mayfield.

Cusack & Smith (1984). *Pets and the elderly*. New York: The Haworth Press. Powley Associates, Inc.

Charmoz, K. (1980). *The social reality of death*. Reading, MA: Addison-Wesley Publishing Co.

Kay, W.J., Neburg, H.A., Kutscher, A.H., Grey, R.M., & Fudin, C.E. (Eds.). (1984). Pet loss and human bereavement. Ames, IA: Iowa State University Press.

Schuyler, D. (1973). Counseling suicide survivors: Issues and answers. *Omega*, *4*, 313-321.

SESSION 5: LOSS EXPERIENCE, DEVELOPMENTAL LEVEL, AND ADAPTATION IN OLDER ADULTS

Overview of Session Content

Loss as a life long experience among elders is discussed. Attitudes of the elderly toward death, developmental level responses, and loss in the later years. Dying and loss of life as a viable choice in adapting to life. Bereavement overload as a phenomenon of aging and healthy patterns of adaptation.

Key Concepts

1. Multiple losses experienced by older persons and their impact in the form of bereavement overload is discussed.
2. Review of Erikson's developmental tasks of the second half of life and ways to encourage the maintenance of integrity.
3. Comparing and contrasting adaptive patterns of coping with loss and death.
4. Description of older adults' attitudes toward death as more accepting and less fearful than younger persons.
5. Discussion when death and dying is acceptable for the elderly individual.
6. Overview of healthful ways to promote physical and psychosocial health among older persons who have experienced losses.

Learning Activities/Labs

Share the assessment of the older adult regarding losses incurred as a part of the aging process. Approaches to counseling and resolution of losses. Meet in small groups of 4-6. The recorder will report major approaches identified to the large group.

Audiovisual Resources

Transitions: Caught at Midlife, (1980)

a. Divorce, 29 minutes

b. Single or Widowed, 29 minutes

c. Intimacy, 29 minutes

a. Divorce focuses primarily on impact of divorce in the male during the middle age period, 2 vignettes of families and divorce situations.

b. Single or Widowed depicts loss through death of a middle aged widower. Second half depicts a widow, the process of grieving, adaptation, and emergence to a new role.

c. Intimacy brings out the life long need for intimacy. Middle aged persons coping with intimacy need, communication, and extra-marital affair.

Suggested Readings

Marshall, V.W. (1980). Last chapters: A sociology of aging and dying. Belmont, CA: Wadsworth.

Marshall, V.W. (1985). Age and awareness of finitude and developmental gerontology. In S.G. Wilcox & M. Sutton (Eds.), Understanding death and dying: An interdisciplinary approach (3rd ed.) (pp. 150-160). Palo Alto, CA: Mayfield.

Peretz, G.M. & Pierce, I.R. (1970). Development, object-relationships and loss. In B.M. Schoenberg (Ed.), Loss and grief: Psychological management in medical practice (pp. 3-19). New York: Columbia University Press.

Silverman, P. (1985). Widow to widow. New York: Springer.

Wylie, B.J. (1982). Beginnings: A book for widows. New York: Pallantine Books.

SESSION 6: LOSS AND FAMILY DYNAMICS AND INTERVENTIONS

Overview of Session Content

Exploration of the aging person and the family; family development and change in the family system. Family systems theory explained together with the process of family counseling for older adults experiencing losses including death during the later years.

Key Concepts

1. Description of the role of older adults in the contemporary family.
2. Explanation of the concept of "filial maturity" as role reversal takes place in the family in which an older person is present.
3. Review of the sources of change in the family system.
4. Explanation of the family systems theory (dyad, family, group, or organization) and how changes take place within this system.
5. Discussion of the process and goals of family counseling as related to the older adult.
6. Family counseling related to loss and changes unique to families with older adult membership.

Learning Activities/Labs

Brookside Manor 1975 ($5.00). Dorothy Bykowski simulation dramatizing the issues of loss and adaptation with the older person and family when the nursing home placement is necessary. Up to 30 students can be involved. Has a leader's manual and instruction sheet.

Sharing in groups the assessment of an older person regarding losses due to death, separation, divorce or suicide. Approaches to counseling and loss resolution. Arrange in groups of 4-6 for discussion. Recorder to share findings with the entire group.

Audiovisual Resources

A Family Support Group in Session, 30 minutes videocassette ($60 rent, $250 purchase, $350 film purchase)

Source: American Journal of Nursing Co-Educational Services
555 W. 57th Street, New York, NY 10019-2961

Actual family support group sessions shown with focus on promoting inner strength. Dynamics of human behavior with focus on the aging process.

Suggested Readings

Peltier, S. (1980). Counseling the elderly and their families. In C.J. Pulvino & N. Colangelo (Eds.), *Counseling for the growing years: 65 and over* (pp. 117-130). Minneapolis: Educational Media Corp.

Rosenthal, C.J. (1986). Family supports in later life: Does ethnicity make a difference. *The Gerontologist*, *26*, 19-26.

Schmidt, G.L. & Keyes, B. (1985). Group psychotherapy with family caregivers of demented patients. *The Gerontologist*, *25*, 349-350.

Stubblefield, K.A. (1977). A preventive program for bereaved families. *Social Work in Health Care*, *3*, 379-389.

SESSION 7: INDIVIDUAL COUNSELING STRATEGIES FOR LOSS

Overview of Session Content

Consideration of counseling with older adults in normal and pathological grief. Goals of bereavement counseling in normal and abnormal grief. Counseling skills helpful in unresolved developmental, physical and psychosocial loss issues. Role of the counselor in various settings. Counselor involvement with counseling of middle-aged adults experiencing losses and changes with older parents and the ultimate loss of death of older significant others.

Key Concepts

1. Review of the counseling skills helpful in assisting the older person to resolve grief from loss related to developmental physical and psychosocial losses.
2. Examination of the various roles of the counselor in grief and loss therapy.
3. Delineation of the role of the counselor of elders in various settings such as the hospital, Hospice, home, agencies, extended care facilities, mental health clinics, and the court setting.
4. Counseling principles and procedures useful in assisting elders in resolving normal grief from loss through death.
5. Review of the signs and symptoms of abnormal grief shown by older persons.
6. Therapeutic approaches, techniques, and timing in implementing grief therapy with older individuals with abnormal grief symptomology.

7. Counseling elders with loss experiences in relation to general and specific needs throughout the bereavement period.
8. Discussion of loss experiences of adult children with parents or older significant others as they undergo the processes of aging and death.
9. Approaches to counseling adults whose older parents and/or significant others undergo losses such as illness, disability, institutionalization, retirement and death.

Learning Activities/Labs

Speaker - a grief counselor who has an active practice in counseling will be presented.

Audiovisual Resources

U.S. Video Format

1. Caring For and Counseling the Bereaved
2. How to Counsel the Older Adult
3. Growing Young

($55 each, $155 for all three)

By Dr. Ashley Montague, New Jersey Institute of Gerontology, P.O. Box 345, Milltown, NJ 08850

Suggested Readings

Corazzini, J.G. (1980). The theory and practice of loss therapy. In B.M. Schoenberg (Ed.), Bereavement counseling: A multidisciplinary handbook (pp. 71-85). Westport, CT: Greenwood Press.

Raphael, B. (1980). A psychiatric model for bereavement counseling. In B.M. Schoenberg (Ed.), Bereavement counseling: A multidisciplinary handbook (pp. 147-181). Westport, CT: Greenwood Press.

Smith, N. (1980). Modes of counseling with elderly clients. In C.J. Pulvino & N. Colangelo (Eds.), Counseling for the growing years: 65 and over (pp. 307-322). Minneapolis: Educational Media Corporation.

Wordon, J.W. (1982). A handbook for the mental health practitioner. New York: Springer Publishers.

SESSION 8: GRIEF COUNSELING, IN GROUPS, COMMUNITY SUPPORT SYSTEMS

Overview of Session Content

Review of the principles and uses of group counseling with older adults related to the resolution of loss issues. Specific types of group counseling including reminiscence therapy, loss and bereavement support groups are included. Major community support services and counseling resources.

Key Concepts

1. Review the therapeutic uses and value of group therapy with the elderly.
2. Methods of developing, maintaining, and assessing the effectiveness of group counseling for loss and bereavement.
3. Discussion of types of therapeutic groups used in the resolution of grief through loss such as reminiscing, grief support groups for various types of losses.

4. Method used in conducting a counseling group for older adults, focusing on loss and bereavement is discussed.
5. Compare and contrast types of community support systems useful in resolving loss and grief such as A.A.R.P., Widowed Persons Service, Hospice care and counseling, Widow to Widow.

Learning Activities/Labs

Attend a group counseling session in the community in a mental health, health care or agency setting. Group should focus on loss resolution, for example - A.A.R.P., Widowed Persons Service Grief Group, Widow to Widow Group, Survivors of Suicide group. Describe and critique, share in class.

Speaker: Hospice speaker - Hospice concept and services offered, individual and group counseling and staff and volunteer support.

Audiovisual Resources

Day by Day, and Survivors, both films can be obtained from Hospice Home Health Care, 23456 Hawthorne, #120, Torrance, CA 90505.

Suggested Readings

Burnside, I. (1970). Loss: A constant theme in group work with the aged. Hospital and Community Psychiatry, 21, 173-177.

Conyne, R.K. (1985). The group workers handbook: Varieties of group experiences. Springfield, IL: Charles C. Thomas.

Evans, R.L., Smith, K.M., Werkhoven, W.S., Fox, H.R., & Pritzel, D.O. (1986). Cognitive telephone group therapy with physically disabled elderly persons. The Gerontologist, 26, 8-11.

Klass, D. (1982). Self-help groups for the bereaved: Theory, theology, and practice. Journal of Religion and Health, 21, 307-324.

Maynard, P.E. (1980). Group counseling with the elderly: Training and practice. In C.J. Pulvino & N. Colangelo (Eds.), Counseling for the growing years: 65 and over (pp. 273-306). Minneapolis: Educational Media Corporation.

O'Bryant, S.L. (1985). Neighbors' support of older widows who live alone in their own homes. The Gerontologist, 25, 305-310.

Saxon, S. & Etten, M. (1984). Psychosocial rehabilitative programs for older adults. Springfield, IL: Charles C. Thomas, Publisher.

Utley, Q.E. & Sylvia, P. (1984). Coping with loss: A group experience with elderly survivors. Journal of Gerontological Nursing, 10, (pp. 8-18).

Zimmerman, J.M. (1981). Hospice: Complete care for the terminally ill. Baltimore: Urbanan Schwarzenburg, Inc.

SESSION 9: THE COUNSELOR'S GRIEF AND BURNOUT

Overview of Session Content

An overview of the counselor's personal losses and reactions to the loss experiences and coping mechanisms of clients. The effects of stress and burnout on the counselor. Methods of healthy coping and survival.

Key Concepts

1. Awareness of personal losses in students' life is discussed as precipitated by client interaction.
2. Introspection to assess for any fears within each student regarding future personal, family or significant others losses.
3. Examination of methods of coping with counselor loss or grief.

4. Signs of burnout among professional counselors are discussed.
5. Discussion of methods of coping with professional burnout.
6. Ethical considerations of the counselor's role in counseling those with losses.

Learning Activities/Labs

Class discussion of the film and personal experiences with burnout.

Audiovisual Resources

A Nursing Support Group: Dealing with Death and Dying, 31 minutes videocassette, ($60 rent, $200 purchase)

Source: The American Journal of Nursing Co-Educational Services
555 W. 57th Street, New York, NY 10019-2961.

Demonstrates the benefits of a peer support group as nurses at Memorial Sloan-Kettering Cancer Center share their working with the dying and their families including death, loss, and mourning. Viewers learn the importance of dealing with guilt, developing appropriate defenses and distance from one's work, using humor, peer support, and time off.

Suggested Readings

Beland, A.L. (1980). The burnout syndrome in nurses. In Werner-Beland, J.A. (Ed.), *Grief responses to long term illness and disability* (pp. 189-213). Reston, VA: Reston Publishing Company.

Bohnet, N.L. (1986). Staff stress. In M. O'Rawe Amenta & N.L. Bohnet, (Eds.), *Nursing care of the terminally ill*. Boston: Little, Brown and Company.

Maslack, C. (1979). Emotional impact on health professional and patient. In C.A. Garfield (Ed.), Stress and survival. St. Louis: C.V. Mosby.

Sanders, C.M. (1985). Therapists too need to grieve: The aftermath of suicide. Death Education, 8, 27-35.

Vachon, M.L.S. (1979). Staff stress in care of the terminally ill. Quality Review Bulletin, 251, 13-17.

Worden, W. (1982). Grief counseling: A handbook for the mental health practitioner. New York: Springer Publishing Co.

SESSION 10: CRITIQUE SYNTHESIS AND INTEGRATION OF COUNSELING FOR LOSS

Overview of Session Content

Completion and sharing of six sessions with older persons regarding physical, social, and psychological losses they have experienced. Focus on how the individual coped and resolved losses and whether or not they continue to grieve. Pre and post assessment of older person's losses. Therapeutic interventions used by the student and response of the older adult client to these critiques of each session by student. Critique by another student. Take home examination.

Key Concepts

1. Sharing of six counseling sessions with an older adult focusing on losses.
2. Critique of each student's session with elder.
3. View a segment of videotape of a counseling session with an older person, made during the eighth week. Critique and discuss in class.

4. Critique of another student session shared and discussed in class.

5. Evaluation of the course.

Learning Activities/Labs

View videotapes of each student session with older person. Critique and discuss.

Audiovisual Resources

Viewing of student videotapes of counseling an older adult experiencing a loss.

REFERENCES

Bozarth-Campbell, A. (1982). Life is goodbye, life is hello: Grieving well through all kinds of losses. Minneapolis: Comp Care Publications.

Colgrove, M., Bloomfield, H.H., & McWilliams, P. (1976). How to survive the loss of a love. New York: Bantam Books.

Doyle, P. (1980). Grief counseling and sudden death: A manual and guide. Springfield, IL: Charles C. Thomas.

Exum, H.A. (1980). Culturally diverse elderly: An overview of the issues. In C.J. Pulvino & N. Colongelo (Eds.), Counseling for the growing years: 65 and over (pp. 197-218). Minneapolis: Educational Media Corporation.

Frankl, V.E. (1963). Man's search for meaning: An introduction to logotherapy. New York: Washington Square Press.

Gallagher, D., Breckenridge, J., Steinmetz, J., & Thompson, L. (1983). The Beck depression inventory and research diagnostic criteria: Congruence in an older population. Journal of Consulting and Clinical Psychology, 51, 945-946.

George, L.K. (1980). Role transitions in later life. Monterey, CA: Brooks/Cole Publishers.

Grady, M. & Strober, S.B. (1980). The expanding role of the behavioral scientist in the death and dying process. In B.M. Schoenberg (Ed.), Bereavement counseling: A multidisciplinary handbook (pp. 88-121). Westport, CT: Greenwood Press.

Kollar, N. (1982). Songs of suffering. Minneapolis: Winston Press.

Kushner, H.S. (1981). When bad things happen to good people. New York: Avon.

Lewis, K. (1983). Grief in chronic illness and disability. Journal of Rehabilitation, 49, 8-11.

Lewis, C.S. (1963). A grief observed. Boston: Beacon Books.

Lieberman, M.A. (1975). Adaptive processes in late life. In N. Datan and L.H. Ginsberg (Eds.), Life-span developmental psychology: Normative life crises. New York: Academic Press.

Lipinski, B.G. (1980). Separation anxiety and object loss. In B.M. Schoenberg (Ed.), Bereavement counseling: A multidisciplinary handbook (pp. 3-35). Westport, CT: Greenwood Press.

Mawson, D., Marks, I.M., Ramm, L., & Stern, R.S. (1981). Guided mourning for morbid grief: A controlled study. British Journal of Psychiatry, 138, 185-193.

Melhush, G. (1983). Counseling the bereaved. Health Visit, 9, 327-330.

Nouwen, H.J. (1982). A letter of consolation. San Francisco: Harper and Row Publishers.

Pulvino, C.J. & Colangelo (Eds.). (1980). Counseling for the growing years: 65 and over. Minneapolis: Educational Media Corporation.

Roberts, S.L. (1978). Behavioral concepts and nursing throughout the life span. Engelwood Cliffs, NJ: Prentice-Hall.

Ryan, D. (1983). Value of religious support for the bereaved. Newsletter of the Forum for Death Education and Counseling, 6, 6-7.

Stephenson, J.S. (1986). Death, grief, and mourning. New York: The Free Press.

Chapter 10

MENTAL HEALTH SYSTEMS

Maureen Kelly, M.A., Executive Director
West Central Florida Area Agency on Aging
Licensed Marriage and Family Therapist

Diane W. Burr, M.A., Center for Applied Gerontology
Training Director, Department of Aging and Mental Health
Florida Mental Health Institute

Thomas A. Rich, Ph.D., S.M.Hyg.
Chair, Department of Gerontology
Director, Center for Applied Gerontology

GEY 6619

MENTAL HEALTH SYSTEMS

Course Objectives

1. To provide an integration of knowledge about the mental health system
2. To develop an understanding of the relationship between the mental health system and other systems - legal, health, and political
3. To develop a comprehensive view of the range of strategies available for meeting the mental health needs of older adults

Course Description

Content

1. Community resources - networking
2. Local, state, and national resources in aging and mental health
3. Linking of the mental health system with other systems (criminal justice, health care providers)
4. Advocacy and social policy issues
5. Competency
6. Guardianship
7. Ethics
8. Prevention
9. A community gerontology approach to older adults

Course Design

This course is presented with a combination of learning strategies, lectures, class discussion, invited speakers representing a number of mental health related agencies, and group activities. Emphasis is placed on class participation, reflecting the philosophy that the class members represent important links within the network of mental health/aging services. Students are expected to read the complete assigned text to acquire a comprehensive view of community mental health as necessary background.

It should be noted that the session content as delineated in this course outline reflects the mental health and aging system as it exists within the State of Florida. This material should be easily adaptable to reflect the mental health system of any particular state.

Course Requirements

Evaluation of students will be based on their performance in two areas: 1) class participation, and 2) one essay of 5-10 typewritten pages. Suggested topics for this essay are:

1. Discuss the future role of state mental hospitals and provide justification for your reasoning. Address the concept of deinstitutionalization from a historical perspective. Explore why there has been (and continues to be) a great emphasis on deinstitutionalization. The major contributions of the community mental health movement to health and mental health care and to society in general should also be discussed.
2. Develop a mental health program. Be sure to address the following: goals, target population (and why), program funding (deal with the politics at the local community level, as well as at the state level), method of delivery, and measurement of program outcome. (Remember to include a description of the service delivery system, the agency the program is a part of,

and how the program will fit into the mental health system.) Also include and justify staff positions.

Suggested Text

Bloom, B.L. (1984). Community mental health: A general introduction. (2nd ed.). Monterey, CA: Brooks/Cole Publishing Co.

SESSIONS

SESSION 1: INTRODUCTION TO THE MENTAL HEALTH SYSTEM

Overview of Session Content

The class begins with an introduction to the mental health system. Faculty and students will describe their own background and experience in mental health, aging and/or human services. Copies of the general course outline are distributed for review.

A working definition of systems analysis is used as a way for the class to begin to focus on the political, social, economic and professional pressures that have influenced the development of mental health services. The first class is structured to provide a historical overview of the development of the community mental health movement.

Key Concepts

1. The history of mental health up to the 1940's
2. Discussion of the history of the mental health movement in the United States with reference to social, political, economic and cultural factors (1940's to present)
3. The role of government and public law in the development of

mental health programs

- Mental Health Systems Act
- Joint Commission on Mental Illness
- Role and Responsibility of the National Institute of Mental Health
- President's Commission on Mental Health

4. Description of the development of the major mental health service facilities available - mental hospitals, outpatient psychiatric clinics, CMHC's and others

Learning Activities/Labs

This class time is devoted primarily to lecture and discussion. Toward the end of the session, students are asked to sit in a circle and brainstorm the following questions: 1. What qualities/qualifications are required to be an effective administrator with the mental health system? 2. Do we still need to use traditional state psychiatric hospitals? If so, why, and for whom?

Materials Used

Pratt and Ketchley, 1980.

Suggested Readings

Bloom, Chp. 1: Community mental health: Domain, history, and critique.

SESSION 2: MENTAL HEALTH PROGRAMMING, FUNDING AND REGULATORY FRAMEWORK

Facilitator: District Program Manager, Alcohol, Drug Abuse and Mental Health for the State of Florida's Department of Health and Rehabilitative Services

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Overview of Session Content

The organization, characteristics, goals, programs and philosophy of the State's Department of Alcohol, Drug Abuse and Mental Health are introduced. Emphasis is placed on the general service delivery system as viewed from the perspective of state government. Additional attention is focused on the relationship between four subject areas: the program planning process at the local level, development of state priorities, budgetary considerations and laws and regulations within which mental health organizations exist and function.

Key Concepts

1. Discussion of the role of the state in the planning, development, support and evaluation of mental health services
2. The influence of federal and state laws and regulatory responsibilities in developing a continuum of mental health services at the local level
3. The nature of the budgetary planning process (to include funding mechanisms and contracting relationships)
4. Discussion of the Baker Act, Myers Act and forensics issues at the state level - to include legal aspects of commitment, civil rights and effects on patient care

Learning Activities/Labs

Lecture and general discussion

Material Used

a. Table of Organization, State Department of Health and Rehabilitative Services, District VI

b. Graph, Department of Health and Rehabilitative Services, Planning and Budgeting Cycle

Suggested Readings

Bloom, Chp. 2: Planned short-term therapy.

SESSION 3: COMMUNITY MENTAL HEALTH SYSTEM STRUCTURE

Facilitator: Consultant, Suncoast Community Mental Health Center and former Executive Director within the community mental health system in Florida and West Virginia

Overview of Session Content

The session focuses on the development of the community mental health center (CMHC) as described in federal legislation. This requires the student to develop an understanding of certain basic principles and guidelines which are applicable in planning a CMHC regardless of geographical or cultural setting.

The students are introduced to the environment of a CMHC through discussions of catchment areas, governance, comprehensive service delivery systems, staffing, funding and accountability issues from the perspective of a CMHC administrator.

There is additional discussion regarding problems and issues faced within a CMHC, including community participation, interagency relationships, political savoir faire and questions of ethics and research in therapy.

Key Concepts

1. The concept of governance and its application to community mental health centers.
    - types of ownership

- locus of control
- organizational design
- relationship of Board, Staff and others
- staffing patterns
- community responsibility
- interagency relationships
- matrix of balanced service system
- funding sources
- data collection/information systems
- accountability

2. Innovations within CMHC's
   - promotion of mental health in the community and primary prevention
   - curative services or secondary prevention
   - rehabilitation or tertiary prevention
   - concept of services provided in least restrictive setting
3. Accountability within CMHC's
   - financial/administrative
   - service production
   - needs assessment
   - quality assurance
   - evaluation/outcome measures
4. Future Trends
   - Health maintenance organizations and their relationship to CMHC's
   - state case management system
   - survival of CMHC's through corporate diversification

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Learning Activities/Labs

Lecture and general discussion.

Material Used

Testimony to the House HRS Subcommittee. Mental Health and Aging, October, 1985, delivered by Pat Robinson, Department of Epidemiology and Policy Analysis, Florida Mental Health Institute, University of South Florida.

Suggested Readings

Bloom, Chp. 8: Assessing community structure and community needs.

SESSION 4: SERVICE DELIVERY SYSTEM - HOW DO AGENCIES FIT IN?

Facilitators: 1) Aging Services Program Manager, Hillsborough Community Mental Health Center

2) Coordinator, Geriatric Services, Manatee Community Mental Health Center, Aging Program

Overview of Session Content

This is the first of a two-part series presented by mental health professionals to compare administration, programs and community relationships in various organizations providing mental health services to older persons. Presenters aim to bridge the gap between community mental health theory, policy and actual program implementation.

The session includes a description of each program, physical facilities, population served, treatment models, medication and medical services, staffing patterns, funding mechanisms, service access, community support and feedback and limitations of the organization.

Emphasis is placed on programs that create a flexible connection for the client within the service delivery system.

Key Concepts

1. Service Structure Overview of CMHC's is grouped into four parts that explore:
   - administration and liaison
   - the direct and indirect services
   - use of consultation, education and training
   - linkage with the community and other agencies

Learning Activities/Labs

Lecture and discussion through case examples.

Small group exercise: Create an ideal program for older persons. Students decide what is missing in programs which they would choose to include in their "improved" program design. Include justification.

Material Used

Handouts by facilitators - Program description, organization structure.

Suggested Readings

Bloom, Chp. 3: Crisis intervention.

SESSION 5: SERVICE DELIVERY SYSTEM - HOW DO AGENCIES FIT IN?

Facilitators: Director, Aging Services, Family Services Centers
Residential Systems Administrator, Gulfcoast Jewish Family Services

Overview of Session Content

This is the second of a two-part series designed to compare administration, programs and community relationships in various organizations providing mental health services to older persons. The major features of these programs are discussed and future plans for each agency are discussed.

Key Concepts

1. Service Structure Overview (of both agencies) is grouped into four parts (continuation of Session 4)

Learning Activities/Labs

Lecture and discussion through case examples.

Small group exercise: The class will break up into small groups. They are asked to develop a mental health program for a specific population. Students will need to take into account funding issues, community response, developing a strategy devised to access those individuals and organizations necessary to obtain their goal. This exercise can be done in a large class much like a board game with groups representing: power (organizations possessing community support and influence); funding (federal, state, United Way, and other sources); and several select program areas. Instructor chooses one student to head each group, then divides the class into these subgroups. Each group is given a specific number of chips (chips are labeled to represent HRS, United Way, etc.). The purpose of the game is for one program group to obtain the most chips in the areas of money and power in order to implement their specific program goals. The game teaches negotiation, coordination, and team building skills.

Material Used

Handouts by facilitators.

Suggested Readings

Bloom, Chp. 4: Mental health consultation.

SESSION 6: INTERFACE WITH SOCIAL SERVICES SYSTEM WITHIN THE COMMUNITY

Facilitators: Planner, Area Agency on Aging
Director of Aging Services, Polk County

Overview of Session Content

This is the first of a three-part series reviewing other aging programs and their relationship to the mental health service delivery system. Emphasis will be on Title III Older Americans Act Programs, Community Care for the Elderly and Senior Centers.

The purpose of this series is to describe the multiple "formal" and "informal" supports often needed by older persons. The full range of services constitutes the "continuum of care."

While each of the services discussed is available in some communities, the full range is rarely available in any one community. The class will have an opportunity to explore the "package" of services required and factors involved in actual service provision (including funding issues; federal and state policy guidelines and at the community level, the functional capacity of the individual; the personal resources available, such as willingness and capacity and informal caregivers to provide care, and the acceptability of the services to the person receiving them).

Key Concepts

1. Service structure overview including funding, staffing patterns, etc.
2. Array of services focusing on those services which are least intrusive and restrictive on the life of the older person
3. Access to services, including any specific service delivery problems
4. Coordination and linkage
5. Evaluation/Quality

Learning Activities/Labs

Lecture and discussion through use examples.

Class exercise: Using specific case examples, students will be asked to work in small groups to develop solutions to each situation using the following elements: (1) general intake and assessment of client's presenting problem, (2) knowledge of all available resources, and (3) follow up on referral to determine which appropriate services have been received.

Material Used

Handouts by facilitators.

Suggested Readings

Bloom, Chp. 5: Basic concepts in prevention.

SESSION 7: INTERFACE WITH SOCIAL SERVICES SYSTEM WITHIN THE COMMUNITY

Facilitators: Program Analyst, Aging and Adult Services, Department of Health and Rehabilitative Services
Managing Attorney, Senior Advocacy Unit, Bay Area Legal Services

Overview of Session Content

Discussion from the previous session is continued in Part Two of this series. Programs and services to be discussed will include: Adult Protective Services, Home Care for the Elderly, Nursing Homes and Legal Services.

Key Concepts

See Session 6.

Learning Activities/Labs

Lecture and discussion through case examples.

Material Used

Handouts.

Suggested Readings

Bloom, Chp. 6: Stressful-life-event theory.

SESSION 8: POTPOURRI - INTERFACE WITH SOCIAL SERVICES SYSTEM WITHIN THE COMMUNITY

Facilitators: Director, Education and Training, Suncoast Gerontology Center

Chairperson, Department of Aging and Mental Health, Florida Mental Health Institute

Chairperson, Department of Gerontology, University of South Florida

Chairperson, Department of Geriatric Medicine, University of South Florida

Overview of Session Content

This is the third session in the three-part series dealing with the continuum of formal services for older persons and how they relate to the mental health service delivery system.

The class will be introduced to the roles of Suncoast Gerontology Center, Florida Mental Health Institute, University of South Florida Department of Gerontology, and the University of South Florida Department of Geriatric Medicine.

Key Concepts

See Session 6.

Learning Activities/Labs

Panel discussion and audiovisual presentations.

Material Used

Handouts.

Suggested Readings

Bloom, Chp. 7: Mental health education.

SESSION 9: CURRENT ISSUES AND FUTURE TRENDS

Overview of Session Content

This session will consist of a brief review of the changes that have occurred within the field of mental health that have had far reaching effects on the methods of providing mental health services.

Students are now in a position to expand their discussion on the larger environment in which mental health service organizations exist. We will focus our discussions on ways to develop a more efficient comprehensive approach combining mental health, medical and social services, as parts of a well managed service system to address multiple problems of older persons.

Key Concepts

1. Review of changes in the field
2. Possibilities for expansion or contraction of mental health services (e.g., greater community involvement, increased scope and resources, use of larger and diverse staffs)
3. Change and innovation (e.g., multi-unit systems coordinated with other services, HMO's, etc.)

Learning Activities/Labs

Lecture and discussion.

Suggested Readings

Bloom, Chp. 9: Community psychology.

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Chapter 11

FIELD PLACEMENT IN MENTAL HEALTH

Victoria K. Dunn, M.A.
Center for Applied Gerontology
and
Department of Clinical/Community Psychology

Thomas A. Rich, Ph.D., S.M.Hyg.
Chair, Department of Gerontology
Director, Center for Applied Gerontology

COURSE DEVELOPMENT CONSULTANT

Larry W. Dupree, Ph.D.
Chair, Department of Aging and Mental Health
Florida Mental Health Institute

GEY 6941

FIELD PLACEMENT IN MENTAL HEALTH

Finding good clinical training sites for graduate level individuals in mental health and aging is difficult. The basic requirements of a good site are: 1) training in a wide variety of clinical skills; 2) an elderly client population; and 3) adequate professional supervision on a regular basis. Most existing training sites fail to meet these essential criteria. A few notable exceptions are at the University of Southern California and some sites now funded by NIMH. The following discussion describes the approach of this project to select training sites and to develop a good field training program.

Course Objectives

1. To provide the clinical practice setting for developing basic mental health counseling skills
2. To develop student case management skills
3. To meet the training requirements for students to become licensed mental health counselors.

The field placement is a highly structured supervised counseling experience providing mental health services to older adults in the age range of 45-100.

A fundamental concept in the development of the curriculum has been the inclusion of practical, "hands on" experiences in the courses themselves. However, while practica have been part of several courses, the primary source of experience built into the curriculum is the internship.

Content

The internship structure includes clinical experience with a primary supervisor, daily supervision, and observation. A weekly seminar on relevant topics such as ethics, team relations, diagnostic issues, and other professional concerns is an important aspect of the placement.

Full-time placement is defined as 40 hours per week for 15 weeks. Students will be exposed to a variety of training experiences including:

1. Intensive individual counseling experience
2. Intensive group counseling experience
3. Exposure to a variety of therapeutic approaches
4. Participation in case management, development of treatment plans and case follow-up
5. Multidisciplinary team experience
6. Intensive assessment experience

Settings

Developing a good internship experience requires more than the elaboration of a course curriculum; it requires finding and obtaining cooperation with a good training setting. Finding appropriate settings for internships requires the consideration of a number of factors.

The setting should provide opportunities to work with a wide range of clients. In addition to working with elderly, students will benefit from work with the spouses, families, and caregivers of older adults. Students are enriched by practical experience with a variety of presenting problems, a diversity in level of functioning, and differing client characteristics.

The staff should be multidisciplinary and able to provide a positive working model of professional teamwork. An important aspect of an excellent internship is the development of an understanding and appreciation of the unique resources provided by professionals from various disciplines. It is critically valuable to know to whom to make referrals and when to make those referrals.

Perhaps the central issue in considering an internship setting involves the quality and quantity of supervision. The qualifications of the supervisory staff need careful review. The setting must be willing to provide interns with an average of one hour of supervision for each 8 hour day of the internship to meet the minimum requirements for supervision.

The setting should provide students with exposure to a diversity of theoretical orientations and treatment modalities. Likewise, the opportunity should exist for training in a wide range of skills. Specific treatment modalities and skills will be discussed in a subsequent section.

The review and selection of settings is the responsibility of the Mental Health and Aging Internship Coordination Committee, composed of representatives from the Gerontology, Rehabilitation Counseling, and Social Work departments, who are appointed by their respective chairs.

Students

Students are expected to work on a full time basis in accordance with the regular work schedule of the agency.

Student Selection

To be selected for internship, it is necessary that students meet a number of criteria. Students should either have a Master's degree or be enrolled in a degree program related to mental health and aging. Normally, students will have successfully satisfied the Mental Health and Aging courses and degree requirements or the equivalent prior to internship.

Prospective students will be interviewed by a representative of the field placement agency. The agency professionals are responsible for making their own determination of acceptability.

Student Evaluation

Both the agency and the university personnel have the responsibility for monitoring student performance and progress. If problems arise, the solution is to be sought through the interaction of the agency head or supervisor and the Mental Health and Aging coordinator.

Students are required to submit a mid-term report and a final evaluation. The mid-term report is to be a description and summation of the student's major activities within the agency. The final evaluation is to be a self-assessment of the student's internship period with the agency. These are to be submitted to the Mental Health and Aging coordinator at predetermined times.

Agency internship supervisors are also required to submit a final evaluation. This should be an assessment of the student's internship experiences and performance. A copy of the Intern Evaluation form is included at the end of this chapter.

There is to be an on-site visit made by the Gerontology Department internship supervisor during the internship period. During the visit, verbal reports will be made by the Agency internship supervisor and the student as to the progress of the student.

Supervision

Intern supervision requires the coordination of agency and university staff. The agency is responsible for providing an intern with a minimum of 5 hrs/week supervision. Supervision must include observation of student counseling and assessment skills as well as discussion of the student's mental health work. A variety of supervisors with a variety of backgrounds and theoretical orientations enhance the internship experience. A primary agency supervisor must be identified to coordinate the internship experience and the student evaluation. At the end of the internship, an Intern Evaluation form should be completed (and a grade for the student's performance should be recommended) by the primary agency supervisor. If problems develop, the agency supervisor is responsible for contacting the USF Mental Health and Aging Coordinator immediately.

The University of South Florida, Department of Gerontology, Mental Health and Aging Coordinator will assign a supervisor from the USF staff. The USF supervisor is required to make at least one on-site visit, including direct observation of the student engaged in mental health skills. The USF supervisor, after considering the agency supervisor's recommendations, assigns a grade to the intern.

Summary

The Mental Health and Aging coordinator will review each proposed site, emphasizing the criteria outlined in the Training Site Guide. Site selection will be the responsibility of the Mental Health and Aging Internship Coordination Committee.

The internship is designed to be a rich clinical experience with varied training opportunities and with multidisciplinary supervision.

University of South Florida
Department of Gerontology
Mental Health & Aging Curriculum

Training Site Guide

Name of Institution ________________________________

Population served ________________________________

Agency director ________________________________

Unit director ________________________________

Type of agency ________________________________

Funding source ________________________________

# of staff _____

Disciplines represented on staff (names & degrees)

Psychology ________________________________

Psychiatry ________________________________

Social Work ________________________________

Gerontology ________________________________

Nursing ________________________________

Mental Health Counselor ________________________________

Supervision available (require minimum of 5 hours per week per intern)

staff name	degree	discipline	theoretical orientation	supervision hrs/week

Treatment modality training available to intern

REQUIRED:

____ individual counseling

____ group counseling

____ case management

____ assessment

DESIRED:

____ family counseling

____ marital counseling

____ development of treatment plans

____ case follow-up

____ multidisciplinary team experience

____ multidisciplinary case conferences

Theoretical orientations used

____ Psychodynamic

____ Cognitive

____ Behavioral

____ Humanistic (Rogers)

____ Gestalt

____ other (describe)

University of South Florida

Department of Gerontology

Mental Health & Aging Curriculum

Intern Evaluation

Student Name ______________________________ Semester ___, 19__

Practicum Setting ____

Agency Supervisor ____________________ USF Supervisor _______________

Performance Evaluation Checklist

	1	2	3	4	5	6	7	no data
Individual therapy skills	_	_	_	_	_	_	_	_
Group therapy skills	_	_	_	_	_	_	_	_
Assessment skills	_	_	_	_	_	_	_	_
Warmth & sensitivity	_	_	_	_	_	_	_	_
Personal appearance	_	_	_	_	_	_	_	_
Professionalism	_	_	_	_	_	_	_	_
Responsibility	_	_	_	_	_	_	_	_
Ethics	_	_	_	_	_	_	_	_
Self-confidence	_	_	_	_	_	_	_	_
Accepts supervision	_	_	_	_	_	_	_	_
Works well with staff	_	_	_	_	_	_	_	_

1=excellent
4=average
7=poor

Recommended Grade:___

Comments (on separate page):

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